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Health Problems of the Schoolroom

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EDITORIAL

With this issue we are inaugurating the new department which was described in detail in an editorial in the June number of the magazine. We hope as we gradually unfold our wings and ascend into higher altitudes that our readers will find pleasure and profit in the discussion of "problems, programs, policies" and interesting devices of general interest to public health nursing services. Contributions are earnestly desired, the only restrictions upon them being those of clarity, general interest, and terseness. It has been deemed necessary to set a limit of 300 words to each discussion, as the space which can be devoted to the department is only two or three pages in the magazine. The initial discussions, all of very real interest to public health nurses we think, will be found on page 545 of this, the October number.

The editor will welcome news from state nursing associations, reports of annual meetings, achievements of individual members, etc., for publication in the News Notes department of the magazine. All such contributions should be sent directly to the editor and should be received by the tenth of the month in order to ensure publication in the next issue.

On page 535 appears the distribution of members and subscribers to THE PUBLIC HEALTH NURSE by states. Nurses in those states where the magazine does not boast a wide circulation may, perhaps, be inspired by the comparison with other more appreciative communities to do a little propaganda work among their sister nurses, who may need only a very gentle reminder to add them to our list.

MEETING THE DEMAND FOR COMMUNITY HEALTH WORK*

By Ella Phillips Crandall

Associate General Executive, American Child Health Association

Introduction

I SPEAK with considerable trepidation, because I have taken great liberty in the interpretation of the subject. I have depended upon Dr. Emerson and Mr. Norton to point out practical ways of meeting the immediate and ever growing demands for community health work, and have wandered far afield. "Much inspiration—very little information."

It is most promising to talk in terms of community health work for it directs our thought at once away from special interests and separate groups of workers and into a common need and a common service. Community itself signifies a common life. Community health then represents a common good, and for purposes of our discussion should be considered in terms of health administration and health education. We of the nursing, medical, and public health professions are so familiar with the field of health administration that I have chosen to speak almost exclusively from the standpoint of health education. In fact my argument lies in both making and meeting community demand through education of the average citizen.

May I state at once my firm belief in the principle of working through and with constituted authorities in all work designed for the public welfare. This does not by any means ignore the importance, not to say the necessity, for private agencies, but it does imply the constant leadership of the government agencies, and carefully developed plans of coöperation between the two groups.

Taking for granted the ultimate responsibility and authority of official agencies and agents, let us remind ourselves that these agents, after all, are servants of the people and that the people practically represent absentee ownership in so far as their *thinking* in terms of citizenship responsibility for health promotion is concerned. Hence my plea this morning is that we teach the people to think and to think together—to think together habitually about health needs. In time this will create a sense of individual and collective responsibility toward health. Consequently people will intelligently demand expert technicians to do their health work for them just as they now engage an architect to build their home, city hall, or schools. It will also tend automatically to supply money and workers and general coöperation through primary essentials.

Adult Education and Training of Children

How can this be systematically brought about? Not, I believe, by forced growth such as that produced by spasmodic stimulation through technical workers or public officials, or self-constituted groups of citizens interested in special projects; not by coercion of laws and fines. I believe there are two measures that will slowly but surely produce the desired results. Both are educational in character: the first, systematic education of the adult population in local communities concerning their own health problems; and second, the training of children in personal, family and community health practices, standards and ideals.

The first step in adult education, if it is to be intelligent and effective is, I believe, through carefully planned and executed self-examination, under leadership from within the community, rather than superimposed from without. Striking instances are at hand of this method of procedure. Citizens'

* Presented at General Session on Communicable Disease, Biennial National Nursing Convention, Detroit, Michigan, June 20, 1924.

committees are being organized. Citizens and officials are together consenting to look equarely in the face their community shortcomings.

Humanity *generally* wants every good thing it can get—collectively as well as individually—when it really knows what is good. What is community "boosting" but the other side of greed for all good things?

Having faced the facts that the community itself has found, self-interest alone leads to search for cure; therefore out of "the people's survey" comes "the people's cure." It is they who take counsel together and call in experts. It is they, then, who plan, with our help, the proposed structure of community health protection.

Do you ask what is new or different in this? One point only. It is *consciously* the people's plans, their responsibility, their work—done for *them* by *us;* and subject to their intelligent understanding, and enthusiastic participation. Nowadays, I think you will grant, we seek their support for our plans rather than their seeking our help for their plans. Perhaps the answer comes, "Well, public opinion supports us, otherwise we couldn't do all we are doing. Witness the overwhelming growth of health work in the last quarter of a century. What, pray, is the object of this meeting, but to discuss how to meet the already overwhelming demand for health service?"

Two Questions

Let me raise two questions. Why are these demands overwhelming and by whom are they made? First: they are overwhelming because there are not enough funds or workers. There are not funds and workers because the people do not understand enough to furnish the funds or to stimulate workers from among their numbers. The present volume of work, as compared with the volume of need, is as nothing. We hardly dare, even the bravest of us, to face squarely its unknown measure. Second: the demands are made in the main, not by the people themselves, who know their own needs, but primarily by small self-constituted, forward-looking, altruistically-minded groups of specialists and interested laymen who seldom speak for themselves but for *others.* According to philanthropic traditions which still obtain extensively, at least in the eastern part of the country, these others are the poor and dependent elements within the citizenship. In other words, the philanthropic, rather than the civic sense is still governing us. A benevolent autocracy, rather than real democracy is at work among us. If the truth be told, it cannot be said that health protection is yet accepted of the people, for the people, and promoted by the people.

Granting gladly and gratefully all that has been accomplished in health administration and sanitary control, we must still admit that it does not compare in extent with the public instruction system of which this nation is so proud. Looking back to the origin of this system, we recall that it came out of a conscious common need because of the demand of the people themselves. Such a demand is always irresistible. Such a demand will be felt and will be met in the field of health education in the next few decades.

If health workers will spend more effort on getting the people to examine their own needs, rather than begging them to accept services they know little or nothing about, that time will be hastened. Last October, Dr. Haven Emerson told a national audience of child health workers, gathered in this city, that they were on the wrong track. He reminded them that they were assuming responsibility that belonged to parents, and that as social workers it was their job to carry that responsibility back to the parents in the homes. My argument is much the same, only I plead it in the name of those same parents as *citizens,* conscious of a community need, as well as of a family need.

Some Experiments

But we should seek also for a process of self-education and self-

direction which might advantageously follow this self-examination. Several quiet, inconspicuous experiments have been going on in our own country of which little has been heard, thus far.

The Workers Health Bureau is an organization which has undertaken to make trade and labor unions conscious of their health hazards and their power to control them by setting up their own health bureaus through which they may buy collectively the health protection which they need. Dr. C.-E. A. Winslow has spoken of this experiment, launched in the most modest way among a few local painters in and about New York City, but now including the Danbury hatters and others, as one of the most significant health movements of which he has any knowledge.

Within a year these men and others, with the directness and clarity of thought born of native intelligence and a terrible need, have gone straight to the heart of the matter. They have said to themselves, "Why bother with medical examinations and laboratory analyses and treatments?" Let us eradicate the causes—let us abandon, by legislation, as the French have done, the use of white lead in the manufacture of paint. They have already gathered their forces and are at work toward this end. This instance alone is enough to show that when the people know, they care; when they understand, they act; when they see the way out, they are willing to pay the price.

Another project not unlike this in general purposes, but built around the community, rather than the union, is the Manhattan Health Society. This has gone a step further in that its object is frankly and positively health promotion, rather than disease prevention. But its growth, at least in New York, is bound to be slower because a sense of common need or solidarity of interest, such as binds together any brotherhood of laborers, is less readily attained. However, I believe there is in small cities, towns and rural districts a great future for such a plan of citizens' coöperative-health protection. I believe that such societies will serve two purposes; they will bring high-grade health protection to those who want it at a price which all but the truly indigent can afford; and they will pave the way for the voluntary transfer of these services from private to public support, as soon as practically all the people want them enough to pay their share on a tax budget.

Moreover, another fundamentally important factor to the maintenance of such work will have been gained automatically. Out of their experience in and responsibility for the administration of the health service the people will have learned what is adequate service, what it legitimately costs, and the value of thoroughly equipped workers.

Out of this experience also will have come the logical remedy for perhaps the greatest single deterrent to successful health protection work, under government control, as we know it in America to-day. When the people turn over health protection to government control they will not lay down their participation in the administration of health. They will rather establish citizens' advisory committees to support and help the health officials.

Citizens Coöperative Committees

Here let me pause to note the mutual aid between public officials and private agencies, which is beginning to be heard of in the land. It is most encouraging. I am thinking of citizens' coöperative committees as a normal outgrowth of this happy relationship.

I have thus far used the word "cooperative" in a more or less general sense. I want now to make it specific; invite your attention for a few moments to the world-wide movement, known as Consumers Co-operation. I shall not enumerate the principles laid down by the little band of Rochdale cooperatives in England about the middle of the last century. In the light of their phenomenal growth their story is as thrilling as the best of fiction. Their membership in England is over four

and one-half millions. In assets their bank is second only to the Bank of England. They grow their own tea in India and Ceylon and transport it in their own ships. Their wholesale business mounts into hundreds of millions of dollars annually.

In Canada, coöperative credit societies are an incalculable aid to their members. In Switzerland, coöperative houses, dairy farms and bakeries are thriving enterprises. In Russia, there were eighty thousand societies when war was declared, and most of these have survived the war and the coercion of the present government. Belgium is famous for its "people's houses" which are maintained for the common good of members, rather than for refunding excess profits to the members at regular intervals, as is the custom of most of the other countries. The people's houses include schools, libraries, musical and recreational centers and other benefits. In Austria, Germany and Holland, extensive provision for sickness care is made.

In Antwerp there is one society, called *de Woldharding,* which has ninety thousand members. For ten cents per week, per person, or for fifteen cents per family in case of a widowed parent, either man or woman, with children, this society provides for every kind of expert diagnosis, surgical operations and treatment, including limited hospital nursing and drugs, and the delivery of drugs. Denmark is called the Coöperative Commonwealth. Coöperatives are now in the majority in its government. Its folk schools are perhaps the most significant and promising development within the movement, and I am told, though I cannot at this moment verify the statement, that they are giving regular courses in health protection.

In America

The movement is slow, slow, slow—in America. Yet there are over one hundred societies in New York City, and more than three thousand in the United States. Why should not America, with its acknowledged leadership in public health, adapt these proven principles and methods of living and working together, to the promotion of health as well as to the production of the common necessities of life—food, clothing, and shelter? Why not carry these principles beyond the marvelous provision for sickness care, of *de Woldharding,* to the larger mission and greater message of health protection? Various coöperative authorities are enthusiastic about the idea. It has had a splendid test in Serbia in the last two years, where five thousand Agricultural Coöperative Societies with six hundred thousand members have resumed operations since the close of the war. I quote two paragraphs from the report of the Serbian Child Welfare Association of America, which is just off the press:

> What more helpful service could the Association render, therefore, than to establish a health promoting organization within the agricultural *zadruga?* In other words, why not graft a health arm on to the agricultural body? This the Association proceeded to do and the result was the organization of a Federation of Health *Zadrugas* which later took over the administration of the health center work.
>
> In organizing health *zadrugas* to take over the administration and control of the health centers, the Association established its health program upon an institution very familiar to the peasant. The peasant already was buying his harrows and hay cutters, and selling his corn, his sheep, his cattle and his poultry through agricultural *zadrugas.* In addition he was borrowing money through a credit *zadruga.* Why, then, could he not buy his medical service, drugs, health materials and essential house furnishings, and procure his sick benefit funds from a health *zadruga?* It would be perfectly natural for him to do these things. Therefore, the Association proposed to have him do these things through the medium of a health *zadruga.*

Thus, the reconstruction program of the Serbian Child Welfare Association of America knits together the community life into a compact social unity. It is a program of real *community building,* the consummation of all the organized efforts of the various social, sanitary and cultural groups of the government and the country at large to prove the public health, child-care and education of the community. Summing it up, it is the whole working for

each one and for all, against the common enemies—disease, ignorance, and selfishness.

Granted, for many reasons, that it would be tremendously easier there than in America, isn't it worth helping the people of America to want and to voluntarily establish their own health protection services? Surely this would richly fulfill the old proverb: "When the desire cometh, it is a *tree of life.*"

When this desire shall have come, it will indeed have created a demand beyond all our present comprehension, but I believe it will automatically, reciprocally, bring its own funds and its supply of workers in larger proportion than ever before. Funds and workers will increase in proportion to the people's recognition of health as a public and private right. *Then,* appropriations for fire, and police, and roads will not so far outreach those for health as they do to-day, and perhaps—*only perhaps*—the expenditures for chewing gum, and tobacco, and movies will not make both health and education appropriations look like pigmies on the statistical graphs of the federal government.

I believe it is not too much to say, after granting freely all the limitations of human nature here as elsewhere, that the principles of consumers' cooperation, as practiced among millions of people to-day, within their governments and not traducing any law, are the most practical application to everyday life of the simple but all inclusive teachings of the Christ.

Health Instruction Through Schools

But there is another great avenue through which to create and to meet the demand for health and health work, that is perhaps nearer and surer in America than any health education that can be brought to an adult population, *i.e.,* health education of children through our school systems. It is already under way. For four years it has been promoted by the Child Health Organization of America and has made extraordinary progress, although it is still only a beginning of what it promises to be.

By health education, I do not mean mere information nor yet health stunts, nor health habits. I mean health attitudes and ideals that grow into the child's growing consciousness, as his teachers learn to correlate health with geography, history, civics, with English and current topics, with school lunches and with play.

Last year in San Francisco there gathered the World's Congress on Education and with it an International Conference on Health Education. Twenty-seven nations sent official representatives. The report of the proceedings has been published in three languages. Fellowships have been awarded to many foreign students of health by the Rockefeller Foundation and the Committee for the Relief of Belgium and others. The Belgian government has introduced a nation-wide program of health education. The Panama Canal Zone has adopted a complete health education program adapted to its present system of public instruction. In India and China and other countries the material and methods developed by the Child Health Organization are in use.

In our own country, during this year, fifty-two cities have entered into the Teacher Scholarship Contest conducted by the Health Education Division of the American Child Health Association which has just awarded $25,000 to fifty contestants, the funds having been provided by the Metropolitan Life Insurance Company. In every one of these cities a citizens' committee has been organized and has carried the responsibility for general oversight of the contestants' health work during the current school year and for making the selection of the three best candidates in each city. The National Committee has chosen the fifty candidates from among the hundred and fifty selected by the local committees out of a total of 1,673 contestants. This story of teacher scholarships during the past four years is a fascinating one, too long to nar-

rate here, but the least important part has been the help to a relatively small number of teachers. Far more important is the fact that it has forced upon the attention of teacher training institutions and universities the importance of introducing sound educational preparations for the teaching of health into the regular curricula for teachers and for children.

In Cambridge a carefully selected body of about one hundred guests, educators, doctors, nutritionists, nurses, physical educators and others are meeting for a week's conference on technical and administrative problems pertaining to health education in public instruction systems, and in teacher training institutions and universities.

The National Education Association has created a permanent section on health education within its department of superintendence. In fact, this movement, less than six years old, has been accepted and adopted by the educators of America, and they are definitely at work toward its further development.

Interdependence

They are seeing ever more clearly also, and I fear more clearly than physicians and nurses, the interdependence of educators, doctors and nurses, and at the same time, of home and school. They are laying foundations deep in the modern science of nutrition. It seems not unreasonable to believe that within a few generations children will come to maturity with a knowledge and an unconscious acceptance of health laws and ideals as far superior to those of the average citizen to-day as the child's knowledge of wireless and radio surpasses that of his grandfather.

With all possible respect for the mission of the health officer, the doctor and the nurse, in the field of health administration and supervision, and these, too, are being trained in special schools and courses, I have no hesitation in saying that it is and will be the grade teacher who will implant health into the heart and character, as well as the mind of the child of to-day, and therefore that it is she who will be laying the deepest foundation for community health for to-morrow. In fact, only when it becomes a part of the subconscious life of the child and the habit life of the family, has the health desire actually become the tree of life, toward which we doctors, nurses, teachers, and parents are all striving.

And when these children have become parents, even the teachers' tasks will be easier, because the parents will have begun the good work long before the sixth year and will share the teacher's lessons with the older child.

For your encouragement, let me say that this, too, is already happening in a few places. Those of you who can and are interested to do so, will be amply repaid by a visit to Newton, Massachusetts; to Fargo, North Dakota; and to Mansfield and Richland County, Ohio. These demonstration centers are pointing the way, in many respects, to sounder community health programs. Especially are these showing how inextricably are all the health and social and economic aspects of life interwoven.

Another Step

In closing, let me carry this thought one step further. Health work to-day, and in the future—both administrative and educational—must flourish through the organization of small community units. The health thermometer of any nation registers not at its capitol but at its periphery, as Doctor Charles William White would say. Nevertheless, it is the common (for community) health of the nation that concerns us—and, if of our nation, so also of the world. In these days of confusion, not to say chaos; of apprehension, not to say suspicion; of wars and ghastly preparations for more wars, there seems to be one almost universal interest in the world. This interest is health.

Dr. Frederick Peterson, who has just returned from India, where desperate diseases almost unknown to us are still rampant, tells us that health education of the children in Tagore's school has already made possible the

extermination of certain of these diseases, such as malaria, from villages where these children have put into practice the health protection measures they have learned.

International Achievements

Whatever you in this audience may think of the League of Nations* as now constituted, or of any *political* league, surely those of you who are familiar with the work the league has already done and is doing through its Health Department on international sanitation, maritime regulations, the study of opium traffic and traffic in women, must be deeply impressed by the fact that already some trustworthy machinery for the promotion of international health knowledge and health administration exists.

And now that the League of Nations has added a Bureau of Child Welfare, the door of hope opens still wider. This, together with the still unexcelled report of the Cannes Conference and the works of the International Health Board of the Rockefeller Foundation and the League of Red Cross Societies, must immensely strengthen hope for the establishment, even though in a distant future, of a world-wide knowledge of, and desire for, health that will demand health education and administration for all people.

In 1920, L. P. Jacks, writing on the League of Nations in an article entitled *The International Mind,* argued that there were at least seven other leagues or "communities" of international life, that would probably have to precede the organization of any political league. He named them as follows:

The Trade Union—or the Community of Labor.
The Friendly Society—or the Community of Insurance.
The University—or the Community of Learning.
The Guild of Fine Arts—or the Community of Excellence.
The Social Club—or the Community of Friendship.
The Church—or the Community of Faith.
The Family—or the Community of Love.

To these seven I will add an eighth—by way of showing that I do not wish to exclude it, but only to put it in its proper place. The eighth is the Political State, which is the Community of Government. All of these by way of training people to think together—by way of establishing an international mind.

May we not with some reason say that an international community of health is even nearer at hand? Is health not the point at which the world can best begin to *think together* in the common language of a universal need and an eternal desire? And may we not hope that from this grain of mustard seed, sown in the soil for the common life of humanity, may grow a tree whose leaves shall be for the healing of the nations?

SUMMER SCHOOLS FOR NURSES, 1924

Last year we reported that about 390 nurses attended the six weeks summer schools held in the various universities and colleges throughout the country. This year we can report an attendance of over 500 nurses.

Most of these students were nurses actually engaged in public health nursing work. Nineteen were completing their required work for the certificate in public health nursing from an accredited school.

The biggest registrations occurred in the institutions where the United States Public Health Service held their institutes, Columbia University, University of Iowa, University of Michigan, University of California.

Exclusive of these six weeks' sessions, a one week institute at the University of Washington had a registration of 125 nurses. The institute of the New Hampshire Tuberculosis Association registered 48, about 200 on part time.

* See Christiane Reimann's article on *Health Activities of the League of Nations* in the August PUBLIC HEALTH NURSE.

HOUSING THE VISITING NURSE ASSOCIATION OF DETROIT *

Central Bureau of Nursing—Detroit

Thirty years ago a nurse, Miss Alice M. Bowen, started visiting nursing in Detroit single handed and without any visible means of support. Her undaunted courage won the interest and support of sympathetic groups of women who in March, 1898, organized the Visiting Nurse Association of Detroit. Miss Bowen was able to continue for only a year in the work she had striven so hard to establish, but nurses, prompted by the same missionary spirit, were found to "carry on." Their salaries, those first years, ranged around twenty-five and thirty dollars, and nursing the poor in their homes was a pioneer venture. These pioneers found a sustaining power in the counsel of the chairman of the Nurses' Committee, Mrs. Lystra E. Gretter, who later became superintendent of the Visiting Nurse Association and continued in that capacity for fifteen years, becoming superintendent emeritus in 1924.

In keeping with the ideas of that period, the year 1900, one of the chief concerns of the Board of Trustees was to establish a comfortable home for their growing staff. The first home was at 15 Elizabeth Street East, a few rooms furnished entirely by donations of furniture from interested friends. When the staff outgrew these cramped quarters, they were moved into a frame house at 224 Clifford Street which proved much more comfortable. Yet this did not satisfy the trustees, for they earnestly desired to have a building which would be a credit to the Association's work. Thus it was that Mrs. Tracy McGregor (Catherine Whitney) who had been in close touch with the nurses' work, built and furnished for them the attractive building shown in the illustration, at 4708 Brush Street.

In 1905 the eight nurses moved into their new, attractive and luxurious quarters which served as home and executive center. There were nine,

* The fourth of the series depicting the homes and activities of voluntary, municipal and State public health nursing organizations.

large, airy bedrooms and three bath rooms on the second and third floors. On the first floor were the living room, dining room, kitchen and two executive offices while in the basement was sufficient space to keep medical supplies for the work, as well as supplies for the house.

In ten years the staff outgrew even this commodious building for residential purposes and hence in 1917 the nurses sought domiciles of their own while the Home was converted into an office building, providing office space for three other nursing organizations: namely the First District of Michigan State Nurses Association headquarters and Central Directory, The Babies' Milk Fund, and the Detroit Home Nursing Association. Thus was nursing in Detroit coördinated for the convenience of the public, making it possible to obtain any type of nurse from the same address and telephone number. The name under which these agencies function is the "Central Bureau of Nursing."

Perhaps as a result of this physical coördination, two amalgamations were made possible, that is, the Babies' Milk Fund now functions as an integral part of the Visiting Nurse Association, while the Detroit Home Nursing Association functions through the Nurses' Central Directory. At the present time, therefore, the building houses three organizations, the First District Headquarters and Directory, the Visiting Nurse Association and the Visiting Housekeeper Association which is a staff of home economic graduates who teach families proper methods in cooking, sewing, and marketing.

As the Central Directory is open continuously the Visiting Nurse Association has an arrangement with them to take night and Sunday calls. For this service a fee of $70 per month is paid.

The Visiting Nurse Association uses four rooms on the second floor for administration purposes, while the three rooms on the third floor are used by the Teaching Center and the night nurses. All the agencies use the reception room and library for their staff and committee meetings and for social purposes. The building is therefore being used to capacity and in this larger rôle of "Central Bureau of Nursing" is playing a more important part in community life than it did as the visiting nurses "Home."

CHILD WELFARE IN SOUTH AFRICA

A scheme for the formation of a South African National Council for Child Welfare has been submitted to the government of South Africa and the question of a grant in aid of the plan is being considered. It is proposed that the National Council shall be the official channel of the Child Welfare Societies with government or other public bodies in matters relating to general policy in connection with child welfare in South Africa, and that it shall carry on propaganda, link up existing Child Welfare Societies, and encourage the formation of new societies, including those concerned with prenatal and maternity work.

The mothercraft and infant care work now being done by certain municipalities should be continued, it is held, and, more especially in large urban areas, this important branch of child welfare work is probably better done through municipal health departments. To prevent overlapping of waste of effort, it is suggested that there should be some form of closer coöperation between the Child Welfare Societies and municipalities in each center.

At the Child Welfare conference held in Capetown resolutions were passed urging the subsidizing of mothercraft training centers by the government and plans for the most efficient method of running them were advanced. —*National Health.*

HEALTH PROBLEMS OF THE SCHOOLROOM

A Message to Nurses and Teachers Regarding Defects and Diseases of School Children

By Dr. LeRoy A. Wilkes

Medical Director for Austria
The Commonwealth Fund

BEFORE one can detect the early signs of departure from the normal state of a group of children, it is absolutely essential that a certain amount of observation be practised upon those same children when the most usual or normal conditions are existing. It is pertinent to note that a surgeon always compares an injured arm or leg with its normal fellow before making a diagnosis. In other words, there is a considerable variation in individual "normals" even under similar conditions.

The ability of an intelligent and observing mother to detect the first signs of departure from the individual "normal" of her child, often before the most expert physician can do so, has been impressed upon the writer in his experience. These indefinable signs, which are only detected by one who is thoroughly familiar with the usual or normal appearance of the individual, are generally included in the rather ambiguous diagnosis which the mother calls "droopy." In cases of the so-called "diseases of childhood" this state is the one in which most of the infection is spread to other children. This fact I believe to be a very important one for school nurses and teachers, as well as parents, to know in order to isolate the child early. The practical application in the case of school children lies in the opportunity afforded the teacher to observe daily for an extended period of time the individual children under her care. She can soon distinguish the lively boy or girl from the quiet one; the one whose face is normally quite red in color, from the one who is paler but quite as healthy so far as a physician can detect. This enables the teacher to diagnose normal children more accurately and as a result, she can more readily and effectively note the early signs of abnormal conditions. Some studies of school children in epidemics have shown that where proper inspection of children was daily practised by teachers, nurses and doctors, the morbidity rate was increased when the schools were closed in an endeavor to stop the epidemic. In the opinion of the writer, the emphasis to teachers should be laid upon their obligation to study the normal appearance of their pupils and to call the nurse and doctor to their aid when departure from the normal is suspected.

Observation of Early Signs of Contagious Disease

Of course many children will escape observation during this stage of indefinite symptoms and come to the attention of teacher or school nurse through one or more of the usual signs or symptoms:

Rash
Sore throat (especially with "spots on it")
Headache
Lassitude
Fever
"Red" (inflamed) eyes often discharging
Chilliness or actual chill, often followed by profuse perspiration especially noted on the forehead
Discharging ears (often contagious)
Nervous symptoms such as hypermotiveness and excitability, especially when accompanying febrile symptoms.

Frequently also there are digestive derangements; pains, usually colicky and intermittent; nausea, and often sudden and violent vomiting. These signs and symptoms suggest the possibility of oncoming contagious infection and the wise teacher or nurse will send such a child to his home at once

to protect his class-mates. It is only necessary to say to the parents that "the child does not appear to be in his usual condition of health and it seems advisable to allow him to return home to consult the family physician." In this way the teacher and nurse avoid the mistake of attempting to make a medical diagnosis and merely state facts observed by them.

Observation of Signs for Early Detection of Defects

There is not, of course, the same urgent demand for immediate attention in the case of physical defects as of contagious diseases, but the importance of detecting them at an early stage cannot be overestimated. The reason for this is three-fold:

1. "Physical defects tend to get worse."
2. "Physical defects tend, in time, to produce secondary defects."
3. "Physical defects finally pass, through neglect, into a non-remedial stage."

(*Cornell*)

I should, however, like to emphasize one point that I believe should be carefully noted by all who have to shoulder the responsibility of examinations, namely, that a physical defect is of importance only when it

1. is accompanied by signs of disturbed bodily physiology,
2. involves pathological changes, or
3. becomes a constant source of worry to the patient (usually from a cosmetic viewpoint in girls).

Statistical classifications of tonsils and other defects are very necessary and of utmost value to any work when they are properly made and evaluated by a person adequately trained for such work, but too often in my experience I have seen nurses following up what I should call "statistically" enlarged tonsils. By such a term I mean that the tonsil was larger than the average size, but was perfectly normal for the individual possessing it, as the throat was sufficiently large to accommodate the enlarged member, and other bodily functions were perfectly normal so far as could be determined. I realize that the diagnosis of these defects is the function of a physician, but I mention this example here because of a tendency school nurses and teachers have to encroach upon this function of the physician in a perfectly honest and sincere endeavor to improve and extend the work. I am afraid such endeavors will react to defeat the purpose, unless nurses have long and special training under competent physician teachers, in which case I believe much can be done along this line. There is no substitute for extended and intelligent experience for both the doctor and the nurse.

The nurse and teacher, nevertheless, should be charged with the responsibility of observing, as in the control of contagious diseases, certain signs and symptoms indicating the presence of defects which are remedial in the early stages. Errors of vision for instance, are often indicated by headaches coming on in school hours, also by squinting and requests for the front seats when exercises are written on the black-board. Breathing through a constantly open mouth suggests nasal obstructions requiring medical attention. Peculiar gaits in walking may be caused by orthopedic defects or diseases of the nervous system. Defective hearing may account for supposed inattention and so-called "stupidity."

It is well to remember also that in certain localities special defects are common, *i.e.*, goiter, hookworm, etc. In such communities these defects, because of their frequency, are regarded as quite normal conditions and parents often express little concern over them and are not easily convinced of the importance of preventive and curative measures. This was true in Switzerland and the Vorarlberg region of Austria where, until the recent demonstrations of the value of iodine prophylaxis, the peasant believed goiters quite a normal condition. Hookworm, which caused the anemias underlying much of the so-called "laziness" and "stupidity" of the mountain-whites in our southern states, had to be persistently and urgently fought by propa-

ganda as well as medicine because of the familiarity which breeds contempt of a common pathological condition. Teachers, therefore, should recognize the fact that common defects found in children of any locality have a significance from the standpoint of the community as well as of the individual, and should consult the local health officer to enlist his aid in their prevention.

Uniform Recording of Physical Defects

In the diagnosis and recording of physical defects in children there is much to be desired in the way of uniformity in diagnosis as to urgency of treatment. I have before me at this time a task of reaching uniformity in recording, which presupposes uniformity in diagnosis. This is still an extremely difficult proposition since we have so many personal equations to contend with. However, the uniform recording of physical defects found will be an inestimable aid to the nurse in explaining to the parent the degree of urgency of the condition found in the child. For instance, the different degrees may be shown in the following way:

0 indicating normal
1 indicating possible abnormality
2 indicating positive abnormality
3 indicating urgent abnormality.

By this means, with only a few explanatory words by the nurse, any of these conditions could readily be made clear even to an uneducated parent. As a suggestion I might say that simple diagrammatic sketches or pictures have been used by nurses on my staff to convey the idea to parents who do not understand the language spoken by the nurse. These can be supplemented by a few words or sentences in the language of the parent. I have seen nurses learn these few necessary words or sentences readily in several languages.

Coöperation of Teacher and Nurse

It is the privilege and duty of the teacher and nurse in the schools to aid in improving the child physically as well as mentally. This is best done by example rather than precept, in both physical and mental training. The teacher must practice consistently the health habits she teaches or good results will not be forthcoming. In mental development teachers have long demonstrated their recommendations, but in health practices unfortunately the spoken word is too often in direct contradiction to the prevailing practices. The importance of proper ventilation is often very well presented verbally while the classroom itself is overheated and often obnoxious to one coming in from the outside. This latter condition is often unnoticed by persons in the room for a period of time because of the physiological fact that the sense of smell can be temporarily dulled by what physicians call "fatigue of the olfactory nerve." A reliable thermometer and frequent trips by the teacher to an open window for a few deep breaths will guard against the conditions mentioned and set an excellent example to the class. Such correlation between didactive instruction and actual practice is impressive and convincing to the children and most effective in influencing their habits in their homes.

This departure from the subject of this paper was made to emphasize the fact that cause and effect may both lie within the school room and that physical defects not only can be eliminated, but in some cases such as anemia, nervous instability, and defective vision due to eyestrain, can be actually prevented by proper practices within the school room.

The work of the nurse can be made much more effective and less arduous when the teacher by teaching the habits of health preservation consistently and attractively to children—and parents too—fertilizes the field for the follow-up home demonstrations of the public health nurse. On the other hand, the nurse has a big opportunity to help in bringing home to the teacher her responsibility in the program arranged to develop the child "below the

eyebrows as well as above." Furthermore, because the teacher has many other duties, and the physician usually cannot afford to give all of his time to public health work, the nurse must endeavor to correlate their work and unify all efforts for the physical improvement of the child.

DOES THE SCHOOL NURSE KNOW

That the American Red Cross has prepared a very comprehensive outline of the work of the rural school nurse, called *Rural School Nursing?* This is a valuable guide to any school nurse in planning and developing her program, and can be obtained from National Headquarters, Washington, D. C. Price thirty-five cents.

That the U. S. Bureau of Education is constantly adding to its list of valuable pamphlets concerning school health work, and that up-to-date lists and prices may be obtained from the Bureau at Washington, D. C., or the American Child Health Association, 370 Seventh Avenue, New York City? Important additions which have been made recently are:

The Kindergarten and Health.	Single copy, 5 cents Additional copies, 3 cents each.
Suggestions for a Program for Health Teaching in the High School.	Single copy, 5 cents Additional copies, 3 cents each.
The Continuing Need for Teachers of Child Health.	Single copy, 5 cents Additional copies, 2 cents each.
Health Promotion in a Continuation School.	Single copy, 5 cents Additional copies, 3 cents each.
Suggestions for a Physical Education Program for Small Secondary Schools.	Single copy, 10 cents Additional copies, 5 cents each.

* That *The Child: His Nature and His Needs* is a five hundred page book, compiled by The Children's Foundation, under the editorial supervision of Professor M. V. O'Shea, and written by sixteen distinguished experts in the children's field? It deals with "Our present knowledge of child nature"; "Our knowledge of what constitutes the child's well-being"; and the "Present Status of our Knowledge of Education." This book can be obtained by sending one dollar to the Publication Fund of The Children's Foundation, Valparaiso, Indiana.

* That the National Committee for Mental Hygiene, 370 Seventh Avenue, New York City, has published a series of leaflets on *Habit Forming for Children* by Dr. D. A. Thom, which can be obtained for ten cents? They are published in separate leaflets or under one cover—the price being the same.

That the National Health Council has arranged with Funk and Wagnalls Company for the publication of a series of twenty books on all phases of human

health written by the leading authorities on the subjects in the United States? These small books can be obtained from the National Health Council, 370 Seventh Avenue, New York City, or from Funk and Wagnalls, New York City, for thirty cents each or six dollars per set. Volumes of particular interest to the school health worker are:

Man and the Microbe	C.-E. A. Winslow, Dr.P.H.
Personal Hygiene	Allan McLaughlin, M.D.
The Human Machine	W. H. Howell, M.D.
The Child in School	T. D. Wood, M.D.
Food for Health's Sake	Lucy Gillett, M.A.
Health of the Worker	Lee K. Frankel, Ph.D.
Exercises for Health	Lenna Means, M.D.
Your Mind and You	Frankwood E. Williams, M.D.
Home Care of the Sick	Clara D. Noyes, R.N.
Adolescence	Maurice A. Bigelow, Ph.D.

That the United States Public Health Service has published, as Public Health Bulletin No. 136, the Report of the Committee on Municipal Health Department Practice of the American Public Health Association and the United States Public Health Service? This report contains valuable information on the status of health work under municipal control, and can be obtained from the Government Printing Office in Washington, D. C., for fifty cents.

That the revised edition of Miss Mary S. Gardner's book *Public Health Nursing* is now available and that it contains excellent chapters on school nursing and on rural nursing? It is published and sold by Macmillan Company, New York, for three dollars.

That the Joint Committee on Health Problems in Education of the National Education Association and the American Medical Association have published a report called *Health Education. A Program for Public Schools and Teacher Training Institutions?* This book can be obtained for fifty cents from Dr. Thomas D. Wood, 525 West 120th Street, New York City. It should be of particular interest to nurses working in Normal Schools or who are supervising health education activities. (See review in this number.)

That a revision of Dr. Newmayer's book *Medical and Sanitary Inspection of Schools* has just been published by Lea and Febiger, Philadelphia, Pennsylvania? Price four dollars.

That *My Health Book,* price ten cents, published by the American Child Health Association, 370 Seventh Avenue, contains a beauty score card which can be used in work with High School and Normal School girls and in Personal and Home Hygiene classes?

That *My Little Child's Health,* price ten cents, published by the American Child Health Association, 370 Seventh Avenue, contains a study outline for the Pre-school child for Parent-Teacher Associations?

That THE PUBLIC HEALTH NURSE is giving particular attention to the needs of the school nurse and invites questions, problems and new ideas from them?

ELMIRA W. BEARS
Secretary for School Nursing, N.O.P.H.N.

* Also of interest to pre-school nurses.

MEETING OF THE INTERNATIONAL COUNCIL OF NURSES AT HELSINGFORS

EDITOR'S NOTE: This announcement which also appears in other nursing journals, needs no public explanation. We do, however, suggest that public health nurses interested in attending the council meetings—and incidentally taking advantage of an unusual opportunity for a vacation abroad—will communicate with their State Association.

What: The International Council of Nurses is planning an International Congress for Nurses.

Where: At Helsingfors, Finland, July 20–25, 1925.

Who: Nurses belonging to the American Nurses' Association, which is a member of the International Council, will have an unusual opportunity to meet prominent nurses from all five continents.

Transportation: The Transportation Committee of the Council is negotiating with The Cunard Steamship Co., Ltd., for one of their ships to sail direct to Helsingfors should the numbers warrant. An alternate plan under consideration is via steamer to England with a short stop at London before proceeding to Finland.

Cost of Trip: New York to Helsingfors, one way, $152 to $160. If special accommodations such as private bath is desired, a supplement to the fare will be charged. Return fare, by cabin steamers, from France or England to New York varies from $120 to $135 and up.

Special Trips after the Congress are being arranged and will be published in the nursing journals.

Below we reproduce the contents of the return postal card which is being supplied by the Cunard Steamship Company, and which will be sent by State Associations to all nurses within the twenty-eight states which up to date have signified their willingness to distribute the cards.

1. Are you planning to attend the Congress in Helsingfors? (Please state "yes" or "no.").....
2. What countries do you wish to visit after the Congress in Helsingfors?
3. About what date do you expect to return to the United States?.....
4. Will you be prepared to pay an installment December first of $50; February first $50; April first $100 and the remainder including cost of post-Congress tours three weeks before sailing from America?.....
5. The estimated minimum expense from New York to Helsingfors and return—a month trip—including passport, board and lodging in Helsingfors will be about $400.
6. Please return this card filled in before November first, if you wish to avail yourself of this special opportunity.

HEALTH WORK IN ICELAND

Eighteen hospitals, a tuberculosis sanatorium, a special institution for those suffering from leprosy, and a small mental hospital are part of the equipment with which Iceland combats the problems of public health. She had in addition, according to *The World's Health*, a school of midwifery, about 200 midwives who are officially recognized, a chief medical officer, with a district medical officer in each of the forty-eight districts, and 25 general practitioners and specialists. A nurse from Iceland, Miss Gudjw Jonsson, attended the 1922–1923 session of the International Nursing Course.

These facts pointing to the modern methods with which Iceland is caring for her people (now numbering 100,000), are significant in view of her history. There were no professional educated medical men, midwives or sanitary officials on the island before 1760 when one medical officer for the whole island was appointed. From that date slow but definite progress was made until in 1876 a medical college was founded in Reykjavik, and since then Iceland has kept closely in touch with developments in medicine and public health.

The infant mortality rate has been reduced to 74 per 1,000, a splendid contrast to the period from 1901–1910, when 121 male and 104 female infants died per 1,000 births.

SOME PREJUDICES AND SUPERSTITIONS OF THE ITALIAN PEOPLE

By Grace Baxter, R.N., and Juliet Turner
Florence, Italy

Editor's Note: We hope to follow this article with others dealing with customs and superstitions of other nationalities.

The Tiny St. Anthony (of Padua) Carried by the Faithful

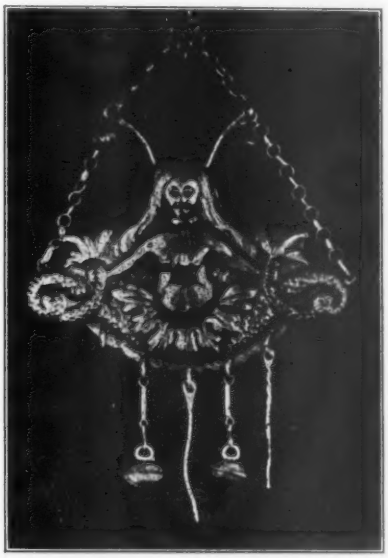
The Italian mind is given to imagery, it revels in the unseen, and phantasy is as inherent to the ordinary Neapolitan or Sicilian mind as a matter of fact point of view is a part of the Anglo-Saxon nature. We say Neapolitan or Sicilian advisedly, since it is naturally in the south that superstitions are most rife, and it is well for those who have to deal with the southern Italian to realize that what seems at first sight to be an almost impossible belief in signs, portents, dreams, evil spirits and patron saints is a very real part of their nature.

If one wishes to gain their confidence and assist them in their difficulties it is better far to instruct by demonstration and let more enlightened ideas prove their efficacy by their results than to try to argue them out of their pet belief.

In every crisis of existence, and in every period of their lives the Italian people resort to practices which seem to us preposterous, but which have been passed on from one generation to another, as valuable rules of conduct.

The question of the patron saints is an interesting one. Why should St. Anthony of Padua be able to find any lost article more easily than his fellow-patrons? Yet it is always he who is called upon in such case and he generally succeeds. St. Anthony the Abbot is the special protector of horses, and on his feast day all the cabmen take up a collection on behalf of their animals, leaving in exchange a tiny loaf of bread and a little prayer to the Abbot Saint. He was old, he was grey-headed, and he must be made comfortable, at least in Naples, hence on the 17th of January fires are lit at all the street corners to keep St. Anthony warm. Santa Lucia helps the blind, and those who have anything the matter with their eyes. St. Anastasia is the saint who should be called upon if a child is inclined to trouble. Put a medal with her effigy round the child's neck and it will be safe.

The Italians are also great believers in vows to their saints. Apart from the usual offerings of candles and votive articles, silver arms, legs, breasts, etc., the southern Italian woman will frequently drive a bargain with a favorite patron saint, promising him that if a particular request is granted she will wear, or undertake that her child shall wear, daily, until it is worn out, the characteristic dress



Silver Charm Against the "Evil Eye," Worn by Children. From "Peasant Art in Italy" by Charles Holme

of the saint in question: wine color for San Ciro the doctor, brown for St. Francis, bice-green with red or yellow respectively for St. Anna or St. Lucia, black and white for Our Lady of Sorrows, or for St. Dominic, etc., etc.

But although the help of the saints is so often invoked, there are circumstances in which other weaknesses become necessary. This is the case when evil spirits have taken possession of a household or person. Exorcism in some form must then be resorted to, and the aid of a holy friar is first called in, who places his stole around the neck of the one possessed by devils. Should the stole remain still, however, the case is not one of true possession, the friar is therefore helpless, and some other explanation must be sought, such as the Evil Eye, etc. The "evil eye" plays an enormous part in the life of a southern Italian and "horns" must invariably be made with the index and little finger of the right hand, on seeing a person who is supposed to possess this unenviable quality. But the evil eye can also be guarded against by wearing a red coral bracelet, or a sprig of rue, or a charm called a "corno" representing the "horns" above mentioned.

Again "witches" have much power for good or evil. They are constantly consulted in their own homes, and drive a great trade with their incantations, prayers, magic powders and other mysterious practices. They can cure the sick, restore the lost, and give any kind of information regarding the whereabouts of the dead!

Among other things they are able to alleviate the discomfort of a child who is suffering from worms by sealing them up inside it—"closing them in with lead" to use the popular expression. Naturally, the child's body being weighted with lead it is dangerous for it to go near water, as it would assuredly drown—hence cleanliness is at a discount.

These are *facts* which we nurses knock up against every day of our lives even in central Italy.

Witches and herbalists also sell some water known as "the water of fear," which must always be on the spot for immediate use if a child gets a fright of any kind, otherwise it will develop worms. Too much laughter in a very small child, however, will bring about the same result.

We now come to the "Lotto" on which 95 per cent of the lower classes and a large proportion of all the others, are firm upholders. This lottery—a government monopoly—is drawn every Saturday in the chief cities of the country, occasionally to the considerable financial advantage of some lucky person. Some startling event which has occurred during the week, or some striking dream will decide what numbers are to be played on, after careful study of the Book of Dreams known as *"La Smorfia"* in which every conceivable name, event and situation is catalogued with its corresponding number: a street fight No. 26, a funeral No. 14, an overmastering fear No. 90, and so on *ad infinitum*. But clear water has one number, muddy water another, still water a third, running water a fourth. In spite of all these technical difficulties lists of numbers are compiled week by week by people who are disappointed every Saturday only to return to the attack with undiminished fervor the week following.

Talking of dreams it is well to remember that to dream of white grapes, raw meat or clear water is so frightfully unfortunate that it is difficult to console the dreamer. The same may be said of candles, coffins and processions which portend death. But muddy water and male children, etc., belong to the category of desirable visions.

Good and bad luck come also by day and in many ways. It is great good luck to meet a load of hay, and correspondingly unlucky if it should happen to be straw. The sight of a hunchback woman brings ill-luck, but to see or better still *to touch* a hunchback man is the height of good fortune. This explains why the former class have always discontented and unhappy faces in Italy while the latter are usually genial and fairly well satisfied with life.

If you meet at the same time a

hunchback priest and a white horse, do not fail to immediately go and play their proper numbers at the "Lotto."

By the same token do not forget that it is lucky to eat fritters on St. Joseph's day, almond and honey cake on St. Martin's, eels and cabbage on Christmas eve, while the festival of St. Lawrence must be duly observed by a consumption of watermelon.

Matters of Hygiene

As to matters of hygiene many superstitions have to be combated, and the bulk of them belong to infancy and childhood. To begin with, washing a baby is considered an unsafe proceeding, and sometimes a child even three years old has never been properly washed. In some communities soap and water are not in general use, and if babies *are* washed it is with bran water or camomile water. A baby's eyes, on the contrary, *should* be washed, but, difficult of belief as it may seem, either urine or spittle is the proper medium. If the baby has worms, and the witches have not intervened, a spoonful of petroleum is sometimes given, with what results may be easily imagined. A dirty head should remain dirty, otherwise milk crust is sure to form. A baby's nails should not be cut or he will assuredly become a thief. All forms of skin diseases are either a natural outbreak which if interfered with will "strike in and cause death," or they are due to a fright. Generally a dog has something to do with the question, but it may be a cow! Fright causes the blood to be churned up, therefore a medicine for the blood is required—not cleanliness. Be sure and give a glass of cold water at once to anyone who has had a fright, it helps to liquefy the clotted blood and brings down its temperature. As soon as possible after this, administer some of the "water of Fear."

The nursing mother who suffers from mastitis has an easy remedy at hand. All she has to do is to tie an ordinary comb tightly over her breast. The reason assigned for this treatment is that mastitis is presumably caused by a hair accidentally getting into the nipple. Therefore, as combs extract loose hairs what more simple than to apply it, leaving it to do its work?

Burns are dressed with cabbage leaves, bruises and skin wounds with flour and water, red eyes have slices of raw potato tied on and earache is treated with the urine of a female child.

But one of the most incredible examples of superstition came out in a conversation with a servant in Florence, not later than a month ago, she stating with absolute conviction that a baby who had disappeared had been stolen to make candles of! This opinion is based on the superstition that a candle made of human skin renders the person holding it invisible and invulnerable. He can, therefore, if he is a thief, steal whatever he likes under the very owner's nose. A worse example than this was in the newspaper yesterday, where it was related that in one of the wildest regions in Sicily a child had been deliberately burnt in its cradle, it being supposed that the sacrifice of a human victim facilitates the discovery of hidden treasure. We give this for what it is worth, but unfortunately with not overmuch incredulity, although we are convinced that it is an extreme and most infrequent case.

One of the most curious superstitions should be mentioned in connection with death. When lice leave a corpse after death, "the lousy vein" which everybody, clean or unclean, is supposed to be provided with, is said to have broken, letting loose its contents. This is firmly believed even by people with a certain amount of education.

Much more could be said, but these few points show that one must approach the Italian family realizing that there is much prejudice and superstition which can only be overcome by striving to enter into and comprehend their mental attitude, while endeavoring to bring enlightenment into their homes.

HEALTH EDUCATION FROM THE STANDPOINT OF NUTRITION*

By Flora Rose
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THERE are three phases of health work which are all now in operation, although the last phase is just being entered upon. These are the curative phase, the preventive phase and the constructive phase. Powerful, well organized and trained forces have long been in the field to cure sick folk and to try to prevent other folk from falling ill. These are by themselves not unmixed blessings. Just as the efforts of society to heal its sick have led to further efforts to prevent sickness, so now the effort to prevent sickness is leading logically to an effort to construct or to build up a type of health in the individual that is more secure and enduring than any conception of health we have had in the past. It is only when we can construct good health that a health program can be regarded as having succeeded in the most fundamental way.

We had long been approaching this point of view when it was opened up to us most completely by the results of the medical examinations made at the beginning of the war to test the physical fitness of our young men for military service. Parents, teachers, doctors, nurses, social workers have all been equally negligent in passing by a child who is thin or pale or poorly developed, or inert, or who is finicky about his food and lacks appetite; who has prominent shoulder blades, enlarged knee joints and "growing pains," but manages along. It is very common to hear the condition of such youngsters described as "nothing to worry about," "something the child will outgrow," "it runs in the family, I was just that way myself as a child," or "he is not vigorous now but he always picks up in spring." The very adults saying these things are more often than not under the necessity constantly of compensating for some needless physical handicap resulting from faulty health in childhood. It is this attitude toward health which the mothers and fathers of our youth still possess. The serious-minded health worker almost grows discouraged when she meets it in extreme form in the "I can't make Johnny" mother and the "Johnny won't do" type of child, the failure to realize that health is a part of conduct to be directed daily.

Collectively, that is as society, we are to-day better than this. Collectively we have at last begun to realize that health is a positive possession and not a negative thing signified by the absence of disease. Collectively we have begun to work to try to build good health as well as to cure and prevent disease. Individually, however, we are still living blissfully in ignorance of what is before us. We still are satisfied if our efforts to secure health reach the point of keeping us from being acutely ill. We have little conception of the part we individually may play in building up forces within our own bodies which will be our best ultimate sources of protection.

These, then, are the problems of health education which society faces: To arouse the individual to a consciousness of the meaning of health, to a sense of his responsibility for it, and to a desire to secure its benefits for himself and his family; to give him the information which he needs as a foundation for building up health for himself and his family; to stimulate and to aid him so that he will act on this information and do the work that is necessary to improve his health habits and to train his children to follow his example in establishing good health practices.

* Read at the Annual Meeting of the National Tuberculosis Association, Atlanta, Georgia, May, 1924.

What part in this program of health education is nutrition to play?

What part does right diet play in curing disease, in preventing it, and in building up healthy bodies?

What part has wrong diet played in reducing health to such a low average?

If we can find satisfactory answers to these questions, the part of nutrition in a health program will be clear.

What Experimental Data Shows

We must not, however, find the answer in individual opinion upon the subject, for each of us working in the health field is more or less governed by the particular health hobby we may ride. We must seek scientific evidence to give us a correct answer.

In all countries where any considerable amount of experimental work is being done to determine the effects of various conditions upon health, scientific literature overflows with evidence that the single factor most deepseated and extended in its influence on health is nutrition. There is an ever-increasing body of experimental data to prove:

The food which the mother eats before her child is born affects not only the condition of the child at birth but its later development as well.

It affects her own general health and her ability to recover from the effects of childbirth.

The food she eats after the child is born is often the determining factor in her ability to nurse her baby.

The food which the child receives may affect its size and shape to an extent which we are just beginning fully to appreciate. It is a potent factor in determining his future health.

Food affects throughout the lifetime of an individual the quality of his muscles, blood, nerves, glands, bones, and teeth; the functioning of his organs; his resistance to disease.

These effects are fundamental and far-reaching and inescapable.

No amount of superstition or ignorance about foods and their values changes these facts by a hair's breadth.

In Other Words

To state the case in other words, the human being is a machine following, it is true, a design determined by heredity, but put together with the materials fed to it. No matter how good the original design of the machine its final value and usefulness are lowered or even lost if the materials from which it was made were poor or inadequate. Sound bodies are in the most literal sense of the word built from right food.

One has but to witness the effects that feeding wrong or poor foods to laboratory animals has upon the original design of the animal and upon second and third generations of its descendants to make one wonder just where in this problem of human health the effects of heredity or original design leave off and where the effects of nutrition begin.

This must not be interpreted as meaning that it is our belief that the only factor operative in producing health is correct food for we are only too conscious of the fact that right choice of food is not a panacea for all ills. It is only to emphasize the fact that without right nutrition good health is as impossible for the human being as durability and service are for a machine built from poor and wrong materials. We can no longer separate the problem of general health from serious consideration of nutrition, for health cannot be built on a foundation of poor diet. It is, however, equally true that we must not separate the problem of good nutrition from that of general health, for a diseased body cannot make normal use of even the most correctly regulated diet. It is only when the two go hand in hand that we shall find a health program functioning in all three phases of its activities: to cure, to prevent, and to build.

The Evidence in the Case

To destroy any lingering doubt as to the importance of food habits in a serious consideration of the health of any individual, let us submit just the edges of the evidence in the case. This may well begin with a short narration of the classic tragedies in nutrition. They all vividly illustrate the old story of the chain and its weakest link, for

each of these tragedies is written about the theme of a weak link, but a link so small and obscure and difficult to detect that it is almost unbelievable that so insignificant a thing could have had such sad effects on human life.

In Denmark the war resulted in a marked increase in the exportation of butter. Many whole-milk-fed babies and children became skim-milk-fed babies and children. A startling number of cases of a serious eye disease followed by permanent blindness resulted. The cause was at once traced to the loss of vitamine A from the child's diet. Later came further news of this same situation. It seems that there were other though less spectacular results of this loss of A from the diet, in the increase in respiratory diseases among these children. It has recently been shown that the lungs of rats fed on a diet rich in A contained more A than the lungs of rats having diets deficient in this vitamin, and what is of more practical importance, that in the rats fed with the vitamin A rich lungs developed a materially greater resistance to respiratory disorders than the others. This story should have particular significance since it more than hints at a connection between faulty nutrition and susceptibility to tuberculosis and it indicates that when the whole story is told one of the best weapons to be used against tuberculosis will be right nutrition.

In the Orient, following the trend of civilization, polished rice, because of its superior keeping qualities, better appearance and more delicate taste, crowded out the old unpolished variety. A serious disease, beri-beri, an inflammation involving the nerves, baffled the scientists for years. Finally it was discovered to be due to the loss from the diet of vitamin B which occurred in protective abundance in whole rice but was deficient in polished rice. Now we know that a less conspicuous absence of B leads to lowered appetite and probably as a result of this to diminished growth. As a result of our own experiments we have been able to encourage appetite and stimulate growth by increasing its abundance in the diet of both animals and humans. When we observe the dietary habits of many children it is not difficult to trace underweight in many cases to poor appetite and poor appetite to a low B content in the daily food.

The ravages of scurvy in the beginnings of America, its toll during the war, its occurrence among babies through all the ages, and finally the discovery that its cause was loss from the diet of vitamin C are thrilling events in the history of nutrition.

The increased incidence of rickets in England which followed the ejection of the small farmer from his holding to make the great landed estates for which England has been famous is a matter of scientific record. Crowding into villages and cities brings in its train changed food habits and less hygienic conditions. Rickets we now trace to lack of direct sunshine or its food equivalent, the antirachitic vitamin. We cure it with sun therapy or eggs.

Goiter has followed in the wake of the pioneer who left his native habitat on the border of the sea to travel inland. It is hard to believe that the small amount of iodin which his new environment fails to supply can so upset the balance of health.

Less Spectacular but Significant

The illustrations selected have been the classic tragedies, so dramatic in action as to force the attention of the world upon them.

They tell nothing of the story of the countless others who have been crippled by too little of a needed substance though not destroyed by complete lack of it. They include only a few of the substances in foods, wrong handling of which may cause nutritional tragedies. Many obscure, less spectacular scenes are those enacted about us daily:

The inadequately fed mother who produces the puny child.

The inadequately fed child who develops into a handicapped adult.

The unnecessary crippling of human be-

ings in ways that seem small, but are important.

The number of six-year molars which are decayed at least as much because of poor building material as because of poor care.

The general poor condition of teeth at the present time because of the fact that we are only beginning to realize that good teeth can only be built from good tooth building materials and that the bread, meat, potato, sugar diet is inadequate to the task.

The noses, throats and mouths which there is reason to believe are defective in shape and in function partly at least because the materials entering into their construction were poor in quality and quantity.

Flat feet, bowed legs and ankles, defective digestion, low resistance to disease.

These all bear mute witness to the effects that poor nutrition may play as one of the dominant factors in governing health.

The Service of the Nutrition Specialist

If the evidence which we have submitted on the part nutrition plays in health building is accepted, then it is clear that nutrition must have a conspicuous place in a program which has as its objective the building up of a healthy race of human beings.

We must, however, realize that nutrition is a highly specialized subject. If we wish to secure healthy people it is not sufficient to organize a schoolroom campaign and get all the children to drink a glass of milk in the middle of the morning. For it may even be that the milk, though good for many of the children, is the last thing needed by this or that child whose parents are already overparticular in this respect. This does not mean that the milk campaign is not a vital part of a nutrition program. It has already demonstrated its usefulness, but milk campaigns by themselves are not a nutrition program any more than milk by itself is a complete food. To build up a correct diet means an intimate knowledge not only of what milk will do for human beings but also of a long and detailed list of nutrition needs and the ways in which these may be met by other foods as well as milk. It is not a question of changing a single food habit but of classifying many food habits each having its own part in human health, and in organizing these into a program of nutrition-health.

This is the service of a specialist in nutrition and the nutrition specialist is now ready or can be found at hand waiting to be called into service. Hand in hand with the doctor, nurse and the social worker must go the nutritionist, each with a special and necessary contribution to make and all working coöperatively to secure the best benefits of health education for the individual.

The problems of nutrition education are the same as those of health education:

First, to create a new attitude on the part of the public and particularly on the part of the parents toward diet practices. To create a desire to know what constitutes good food habits and a wish to make their own food habits and the food habits of the family conform.

Second, to give to this eager public, and people will be eager if the work has been well done, the information which is needed to enable them to choose their food wisely.

Third, to stimulate them to eat wisely and to give them every possible aid in following good food habits.

As an integral part of the health program it has the same fundamental aim—and that is to make healthier people and to make people so far as possible conscious of their individual problems and responsible for them.

EDITOR'S NOTE: This is the third of the series on problems of nutrition. It will be followed by an article on *The Dispensary in the Community Nutrition Problem*, by a physician and child specialist.

WOMEN'S ZIONIST ORGANIZATION

Training Nurses for Public Health Work in Palestine

A plan for health work so well organized that it would do credit to the most modern of cities, has been developed in historic Jerusalem by Miss Bertha Landsman, whose work is sponsored by the medical organization of Hadassah, the Women's Zionist Organization, with headquarters at 114 Fifth Avenue, New York City. Miss Landsman, who has spent four years in the Holy Land, writing to a member of the N.O.P.H.N. staff, gives a comprehensive picture of conditions in Palestine and the way in which health problems are being approached. She also sent an interesting outline of the instructions given to the post graduate nurses in the Hadassah Medical Organization training school for nurses.

I started the infant welfare work here in 1922, with one center in the old city, inside of the old city wall, and there I also established a milk kitchen along the lines of Nathan Straus' kitchen; the other center was outside of the city wall, in the section called the New City. I had no nurses who understood infant welfare work, and therefore had to work with the pupil nurses from our hospital training school. Each nurse stayed with me for three months, and every three months I had to begin all over again and teach. The work, of course, was not as thorough as might be expected if I had had trained help. Besides training the nurses and organizing the work, I also had to win the confidence of the mothers, and assure them that I was only interested in the *welfare* of their babies. The population here is superstitious, ignorant and very poor.

Now, after two years, I have four infant welfare centers, and each center has a trained infant welfare nurse (my former pupils). Each of our centers has about 200 active cases, and our work is very gratifying indeed. Most of our mothers have had ten and twelve children, and the babies attending our centers are the only ones alive. The great majority are young mothers, in whom I am especially interested.

In the milk kitchen we make formulas for the babies who do not get sufficient breast milk, and each mother must pay a fee for the milk according to her economic condition. If the home conditions are at all satisfactory, we teach the mother to prepare her own formula.

The health nursing course presents a two-fold problem. I must organize the agencies, and train the nurses. I have done it in the following manner.

One of the Chain of Hospitals in Palestine Maintained by the Hadassah Medical Organization

The Old City infant welfare center I changed into a health center. On Monday morning, the infant welfare doctor is in attendance, on Thursday afternoon the prenatal doctor is in attendance, and every day the school doctor is in attendance. Each nurse was given one street, and she acquainted herself with all the families on that street. The first month of her course, she was on clinic duty in the infant welfare clinic in the morning, and her home visiting was done in the

afternoon, teaching infant welfare, etc. The second month this nurse was on clinic duty in the prenatal clinic, and she did maternity district nursing in her street, with our midwife and doctor, also the infant welfare work as before. The third month, she accompanied our school doctor every morning, assisting with the physical examination in the schools, and in the afternoon doing her home visiting. The fourth month, she made daily class inspections, eye treatments, skin treatments, and general school nurse's duties in one of the schools in the morning, and in the afternoon, home visiting, doing prenatal, district maternity nursing, infant welfare, and school work among her families. The fifth month she attended daily the school clinic, where our doctor examined the ill children. The sixth month was devoted to the station management and home visiting. Nurse No. 2 followed the same routine, but a month later, with another street in which she did her district visiting. I planned it to be an endless chain of nurses, one following the other, and while this is not satisfactory on account of the frequent changes in the clinics, still the district was cared for by one nurse for the whole of her six months' training. I am hoping if this course is continued and included in the curriculum of our hospital training school, that I will have trained workers in charge of the prenatal, infant welfare and social work, and the pupil nurses will work with these trained workers as their assistants, and in this way the work will carry on quite steadily. Each nurse will have her own street to care for.

A Mothers' Class—Tiberias

Prenatal and Maternity Service

The prenatal work is growing very rapidly and satisfactorily, and I am following along the routine of the New York Maternity Center Association. The infant welfare work is already established, and the school work is progressing most satisfactorily. The teachers and principal have already marked the vast improvement in the personal hygiene and interest of the pupils. I have selected a boys' school of the very poorest elements. I am planning to form Little Mother's clubs in our girls school as soon as I get the proper working staff.

My nurses are also doing maternity district nursing among their families. The mothers are instructed to call for

the nurse as soon as she is in labor, then the midwife. The nurse prepares the room and patient for delivery, and if the midwife does not arrive in time, the nurse delivers the case. Our nurses also receive a certificate for midwifery. The theory is given by our doctors, and our nurses must pass the examinations.

Plans for Generalized Work

After we have a staff of nurses trained, I am planning to do general health nursing in all of our centers. That is, instead of doing only infant welfare work in our present four centers in Jerusalem, the nurses will do the prenatal, infant welfare, school, etc. This cannot be done, however, until some of the nurses are trained.

We have had a call from one of the colonies for a health nurse, and I am sending one of my post graduate nurses to this community. I will organize a center for the prenatal, natal, postnatal, infant welfare, school, also preschool work. The community is giving the room and the servant, and Hadassah the nurse, equipment and supplies. The nurse will also do the deliveries in this community. She will treat the eye cases, of which there are many, especially in the hot months.

The work will be planned as follows: From 8 A.M. to 10 A.M. every morning, the nurse will be on duty in the school, for inspections, 10 to 12 A.M. on duty in the station (infant welfare, prenatal, and preschool instructions). In the afternoon, home visits. One afternoon a week for the infant welfare doctor's consultations, one afternoon for prenatal consultations. There are in this community about 60 babies under two years of age, and about 80 school children. I am hoping that this schedule will prove satisfactory. If there are indications for changes, as the work progresses, the changes will of course be made.

In Tiberias, we have also started a center of this sort, and the work is progressing slowly. The population does not yet understand just what we want to do for them, and are a little slow in coming forward. The results and coöperation in Jerusalem have been so overwhelming, that my enthusiasm is very keen.

The dubious distinction of being the only registered nurse in Bahia, Brazil, a state larger than Texas, belongs to Miss Lydia Hepperle of the U. S. Public Health Service, who is daily coping with conditions which might be expected to cause the strongest soul to flinch. But her recent letter to Miss Lucy Minnegerode describing the conditions under which she works reflects no discouragement, rather a lively interest and hopefulness.

To-day, while I was working at our little adobe building we call our hospital, and it is the only hospital for several hundred miles, I was chiefly concerned with the sanitation problem. Our station is located a hundred and twenty miles from a railroad, and we are about three centuries behind our progressive neighbors north of us.

Hygiene, personal and otherwise, is almost an unknown quantity; our natives live in small, unventilated mud or adobe shacks, families of ten and twelve are found in a room or two, without a window, and the doors are closed at sunset so that the evil spirits can not come in and create a disturbance or inflict an illness on a member of the family. They eat with their fingers and sleep on a twig litter or on the hard earthen floors.

This is a malaria district and we are trying to sanitate the valley. All work of that type is very slow and very difficult, due to the lack of workmen and the proper machinery. All freight is hauled mule-back and it takes several months to get here and oftentimes more, and the heavy machinery we can not get here at all.

Posters and illustrated literature can be a great help to us, as that is the only way we can teach the great masses. More than 85 per cent of the people are illiterate and need to learn by object lessons.

COMMUNICABLE DISEASE NURSING IN A MUNICIPAL HEALTH DEPARTMENT*

By Elsie Hickey, R.N.
Department of Public Health, Toronto, Canada

IN presenting the problem of communicable disease nursing from the aspect of a municipal nurse, I find it necessary to give a brief outline of the organization of the Division of Public Health Nurses of the Department of Public Health, Toronto.

Toronto has a population of over half a million and an area of thirty-two square miles. For the purpose of administration of the medical, dental and nursing divisions, the Department of Health has divided the city into eight districts. Each district has a full time medical officer and a superintendent of nurses.

The average population assigned to each district is 66,000. The average staff of nurses is eleven. Always emphasis is placed upon the educational aspect of the work, in homes, schools and clinics.

It has been found that the Director of the Nursing Division and the District Superintendent require, also, a staff of special nurses to concentrate upon certain aspects of the work. There are five of these supervisors—one for infant welfare and prenatal, one for school, one for tuberculosis and hospital extension, one for mental and one for venereal diseases. They keep in touch with the changing policies of the coöperating agencies, the majority of which concentrate their efforts upon age groups or selected medical or social problems. The supervisors bring the experience of these specialists to the division and help formulate the policies governing team play, as well as assist the director to standardize the work of the nursing division.

Owing to the fact that the Victorian Order of Nurses and St. Elizabeth Order efficiently meet the problem of bedside nursing in Toronto, the municipality is glad to leave this responsibility to them, except in tuberculosis or cases which are complicated by acute communicable disease.

Department Activities

The control of communicable disease is one of the essential activities of the department of health. The isolation hospital, which is administered by the Department of Public Health, admits scarlet fever, diphtheria, measles and smallpox. This is Toronto's only municipal hospital. Notification of all admissions and discharges are sent by the hospital to the health district concerned.

On admission, one visit is made to the home from which the patient has been removed. This visit is for the purpose of checking cross infection and to teach the care of the contacts, the necessity for watching for symptoms, the early recognition if symptoms develop and the early calling of the family physician. The nurse endeavors to learn whether the patient has had or been exposed to any other communicable disease within the past month and reports her findings to the hospital. On discharge at least two visits are made, the first one immediately, the second one within two weeks. These visits are made for the purpose of seeing that the patient is receiving proper care, also as a safeguard to the hospital. The general condition and the condition of ears and nose is ascertained and a report sent to the hospital, to be filed for reference. The physician in charge states these reports are invaluable to him, and have often helped to clear the hospital, when criticisms have been made, if patient later develops a discharging ear, or if a second case develops.

* Presented at Meeting on Communicable Disease Nursing, Biennial National Nursing Convention, June 18, 1924.

Home Care

The organizations giving bedside care do not visit homes where there is communicable disease. These homes are referred to the public health nurses and it is their duty to make arrangements for all nursing care and other needs of the home. In the majority of cases, where the family cannot pay for a nurse, the patient is sent to the hospital. If this arrangement cannot be made, and the doctor in charge recommends that constant nursing is necessary, the city assumes the responsibility, as required by the Public Health Act, of providing a trained or practical nurse, as the case demands. If, however, hourly nursing is sufficient, the public health nurse undertakes this service, in conjunction with her other duties. No difficulties have been brought to our attention by this procedure. The rules governing these visits are quite simple:

1. Only one nurse to visit quarantined home.
2. Use a gown when nursing care is given—leaving it in the home.
3. Wash hands after giving nursing care or examining contacts.

Dr. Hastings, our Medical Officer of Health, believes that the nurse who has had a good surgical training and so understands asepsis, and also understands the mode of transmission of disease, is quite capable of giving this service without in any way endangering the public, in so far as the spread of infection is concerned.

The department employs quarantine inspectors and the nurse has no responsibility for quarantine except to notify the inspector if she knows quarantine is not being kept.

One of the principal aims of school work is the control of communicable disease and this is done by regular class room inspections and inspection for readmission after illness. Every child, who is away from school for two days or more, on account of illness, must report to the nurse before he can be readmitted. In this way many a mild case is detected, and the history of contact revealed. Then, too, if a nurse suspects a child in school, she excludes him and asks the district doctor to visit.

He visits all cases excluded as suspects from school. When a positive diagnosis is made he tells the parents that the Department does not provide medical attention and advises them to call their family physician, thus definitely placing the responsibility for care upon them. When the family cannot afford the service of a physician, the Department assumes the responsibility for medical care as required by the Public Health Act.

The nurse may take a swab of a suspected diphtheria carrier, but may not take a swab if clinical symptoms are present, unless by a doctor's order, since a report on the swab might be waited for instead of an early diagnosis being made and antitoxin given.

This, briefly, is the share that the public health nurses take in the problem of the control of communicable disease.

Miss Dock sends us the following note of historical interest in connection with our recent articles on communicable disease:

It must be quite thirty-five years ago that I heard Dr. John S. Billings (the elder Dr. Billings—he who planned the Johns Hopkins Hospital) make a declaration which was then listened to by the learned with incredulity bordering on pity, and which has been recalled to me by articles on modern technique in visiting patients with contagious disease. He was talking about germs of infection and the possibility of working out aseptic (it was called so in the ancient days) methods of controlling them and he illustrated his remarks by saying,

"With perfect details of aseptic management, a nurse could take care of a scarlet fever case in one corner of the room, measles in another, diphtheria in the third, and erysipelas in the fourth corner, without any danger of cross infections!"

L. L. DOCK

GLIMPSES OF WORK AMONG THE INDIANS

By Augustine B. Stoll, R.N.
Red Cross Public Health Nursing Service, Jicarilla Reservation, New Mexico

Editor's Note: In December, 1923, we published an article on *Welfare Work Among the Apaches* by Miss Stoll. These picturesque bits are extracts from her reports to the American Red Cross.

A Medicine Dance

WE had a medicine dance in the waxing of the past moon. I was there and several of the medicine men came to greet me. We discussed "our patients." The dance was really a fascinating sight: There were camp fires scattered over the hillside with one or two huge bonfires as signals. In the center of all was a big corral made of interwoven tree branches. Entering the gates, we were separated from the men of our party and sent to join the women's group squatting on its designated side. Eight fires within the enclosure gave us a soft, flickering glow of light and overhead the moon watched. Along the edges were the Indians, gay in orange and red. Some of the young girls wore the very beautiful buckskin "debutante" dresses with the many hidden tinkling bells. I knew many of them and so had shy, friendly smiles. At the further end of the corral was the medicine tent. In it were six women and one man. All were waving the sacred eagle feather to the rhythm of the tom-tom. The medicine men were marvels to behold; beaded jackets, brilliant blankets, feathers, embroidered "G" strings flopping about their leggings. It thrilled my color-loving soul even though I knew that they had been four days away from their flocks and that their money should be used to increase their number of sheep, or saved for the winter, and not for this expenditure of uncertain value. The dance itself was fascinating in rhythm and simplicity, in portraying good and evil.

We stayed until midnight only, thereby missing the sunrise ceremony, when all go forth from the corral and greet the dawn, throwing the sacred grain before them which drives away all the evil spirits.

Color

This lovely out-of-doors month, I have wandered up and down canyons, struck off across sage brush prairies,

Miss Stoll and one of her good friends of the Rosebud Reservation

searching for elusive tepees or following up a plume of smoke. At times I cling to my steering wheel as my car and I go bumping along, way down into arroyos through the sticky mud to climb toilsomely up the other side and bump along again. A camp once located does not stay put! so I am planning some regular routes and my maps *are* a bit original. The country here varies greatly; near Dulce we have narrow winding canyons with cabins

on the hillside; to the south are the big open prairies where shade is not and nothing but prairie dogs and cattle thrive; to the east are more prairies cupped in by the distant mountains where grow the beautiful big yellow pines. Crisscrossing these open places are many roads or trails which one has to try out, for signposts there are none.

* * * * * *

This has been one of the coldest January's on record. Early in the month we had heavy snows followed by brilliant cold days with the thermometer hovering about 20 degrees below for many nights. The main roads were quickly broken and I made long trips over the frozen snow, almost dazzled by the intense white and blue. I carry a shovel and work it many times, for in a second the car would leave the road and be in a snow bank; and snow is worse than New Jersey sand. I have made many trips by car, horse, sleigh and wagon, and I have a designing eye on the logging train when the spring mud arrives.

There is an Indian here who dreams dreams in the biblical style. He has dreamed two feet of snow for us for February, but against it I am putting the flock of blue birds that I saw yesterday.

Work

This month has been packed so full of unusual events and the days and nights are still so busy that I have no time to write as fully as I should like.

Early in the month, the two doctors of the Mill Town were absent for two days. Immediately a "flu" epidemic started. I was busy going from house to house. Often as I left one home I would find two or three Indians waiting for me, wanting to take me to their homes. It was very interesting, but a responsibility I did not willingly assume even in the doctors' absence.

Next came the news of a railroad accident. The train had rashly stopped between stations and then, without reason, one car after another just toppled over, a bit too tired to go farther. The few people who were injured were brought to the hospital and I assisted there. One man with a broken jaw, hurled through his wired teeth, "You may make me eat soup, but you can't make me stop talking." And right he was!

"The Evil One"

One Sunday a week ago, an Indian came to tell me vaguely of a sick woman in a cabin up one of the canyons. I started, thinking I was on a wild-goose chase, but I found a seriously ill woman. I sent for the doctor immediately, but when he arrived she was unconscious and there was nothing to be done. Very shortly, she died, leaving five children under seven years, the youngest being but two weeks. With me in the cabin were two squaws and the five children. I told the women that the mother could not live long. Immediately they brought forth a bag of herbs and looked at me. I nodded, because I knew they would be happier trying to do something. Then they produced a flat stone and a mallet, and kneeling, they ground the herbs to fragments before adding a little water. All the while they crooned a mournful little song. After a little they carried the mixture to the sick woman, but when they saw she could not swallow it, they crouched beside her with noses covered, groaning softly. I told them when the woman stopped breathing, and though I had been forewarned as to what might happen, I was startled by the rapidity of the events that followed. Both squaws sprang to their feet, snatching their blankets about themselves. Each caught up two children, crowded them under her skirts and was gone. I was left alone with the baby. As I gently covered the dead woman's face, I could not help but compare the loving care of our own dead with this wild haste to get away before the Evil Spirit touched another.

I stayed with the baby in the cabin, which will of course from now on be deserted. Very soon the squaws returned, gathered a few necessities, and then turned for the baby. I did so much want to keep him, but I thought

I had better not suggest such a thing just then. I had just begun to gather up my things when the door opened, both squaws beckoning me to come outside. They thrust the baby at me, saying, "You—take—hospital." I was so glad the advance was theirs. They waited until I finished my packing, then they fitted the baby (mostly blankets) into my arm, and off I started back to town, baby on one arm, bag dangling from the other.

Funeral Ceremonies

During the month I heard of a sick child 'way out on the reservation. I reached her by car and by walking, and a very, very sick little girl she was. The doctor and I went back in the morning and I stayed. The child died about nine that evening. I covered her and went into another room, trying to make myself small and inconspicuous, for I thought maybe they would turn against me. The relatives trooping into the room where the child lay began the preparation for burial by chanting and wailing. After a little, they called me in to see if I approved, and then I stayed and helped. Beautiful Navajo rugs and shawls were spread on the floor, new dresses, large and small, were added, and the child was placed upon them. One after another, the mourners brought beautiful silver bracelets and rings, beautifully beaded strips of buckskin, and I put them on the child. The great-grandfather colored the child's face a deep red with blue marks on her cheeks and forehead. Then with buckskin thongs they wrapped her securely with her gifts in the blanket. She had ridden a little, so a beautiful saddle was placed at her feet. Bundles of her clothes were about her. Just as I was wondering about the dishes she had used, they were gathered and placed with the other things. When all was finished, the squaw entered the house with a big stick and went into each room striking all the walls—to drive out the shindies! It was quite weird. This over, we all went to a small adjoining cabin where a huge fire roared.

In the morning, the grandfather, so tragically dignified, drove away with his dead. He was to bury her in his little plot of ground on the hillside. Twenty-three of his family lie there.

LIST SHOWING DISTRIBUTION OF "THE PUBLIC HEALTH NURSE" BY STATES

Alaska	5	New Hampshire	41
Alabama	27	New Jersey	232
Arizona	12	New Mexico	21
Arkansas	18	New York	1,108
California	275	North Carolina	57
Colorado	71	North Dakota	21
Connecticut	248	Ohio	445
Delaware	18	Oklahoma	38
Dist. of Columbia	80	Oregon	45
Florida	31	Pennsylvania	495
Georgia	68	Rhode Island	127
Idaho	9	South Carolina	38
Illinois	404	South Dakota	26
Indiana	143	Tennessee	89
Iowa	133	Texas	106
Kansas	102	Utah	14
Kentucky	94	Vermont	17
Louisiana	17	Virginia	100
Maine	62	Washington	99
Maryland	69	West Virginia	61
Massachusetts	601	Wisconsin	171
Michigan	398	Wyoming	12
Minnesota	192		
Mississippi	17	Canada	179
Missouri	229	Foreign	165
Montana	20		
Nebraska	41	Total	7,091

MATERNITY NURSING AS A PART OF A PUBLIC HEALTH NURSING PROGRAM*

By Nellie Jewell, R.N.
Supervisor, Maternity Department, Public Health Association, Wichita, Kansas

THE need for a special maternity service had long been felt in our city before the Wichita Public Health Nursing Association was considered by its executives to be on a firm enough footing to undertake organizing such a department.

Plans for organizing were discussed at a meeting of the Medical Society. A committee of three doctors was appointed, one general practitioner and two obstetricians, to work out a standard technique to be used by all doctors.

By the middle of May, 1923, all plans for this addition to the Association had been completed. Two special maternity service nurses were employed to carry on a day and night service. The enthusiasm and interest of the staff and its friends gave the new department such a good start that its success was evident from the first.

However, it takes more than interest to carry on this work successfully. It must be thoroughly organized and arrangements made for charges and cases unable to pay.

The Cost.—We find this is an expensive service, but feel the expense is justified. We participate in the Community Chest this year. This maternity service is financed by the sum we receive from the Chest. Next year it will be included in our budget submitted to the city commissioners. There is a special appropriation made possible by a law passed by the Kansas Legislature in 1919, which enables all cities of the first and second class in the state to levy a tax of .5 of a mill for the support of a public health nursing association in that city.

The Personnel.—Two nurses give full time to maternity work, and are on call alternate days and nights. The nurse who is not "on call" may be called for a delivery if a second nurse is needed, or if the one "on call" is already on a case. If there is need for a third, a nurse from the staff is called. Both nurses make prenatal calls and make supplies for the department. The nurse on call telephones the office every half hour, when making calls.

One afternoon off duty is allowed every week. The nurse taking a half day leaves at noon and is not called at night unless a second nurse is needed. Alternate weeks, the nurses have Saturday afternoon until Monday morning off duty. Nurses arrange to have alternate holidays. All time between 5 P.M. and 8:30 A.M. and Sunday spent on duty is allowed the nurse the next morning.

Prenatal Calls.—Maternity nurses make prenatal calls to instruct mothers as to preparation for their confinement, and to become acquainted with the patient and the home conditions. Prenatal cases are referred to the Maternity Department by the visiting nurses, the physicians, by friends and members of the family or by the patient calling the Nursing Association and asking that the maternity nurse call at their homes. Occasionally we find a mother who has not made any preparation for her confinement, or who has not consulted any physician. We urge these to attend our prenatal clinic to be examined and advised.

Prenatal clinics are held once each week. Patients come every two weeks to have blood pressure taken, and bring a specimen of urine to be examined.

All cases that are likely to be free cases are referred to the county physician, and a record of findings of each case is mailed to him. We like to have cases referred early in pregnancy. Frequent visits to the physicians' offices result in getting a good many cases. They are always glad to refer the cases, but are too busy to telephone.

* This is the tenth of the series of articles on "Can a Satisfactory Maternity Service Be Carried On as Part of a General Health Service?"

We are always glad to take an emergency call, but do not take any night calls unless they are from the physicians. Night calls come through the physicians' exchange.

Some physicians prefer to have the nurse watch the patient and call them when the child is ready to be born. This does not always meet with the approval of the family, nor is it so satisfactory to the nurse. Our average service is four to six hours for a delivery. There have been instances when the nurse remained as long as fourteen hours, reporting to the physician every two or three hours.

Histories of deliveries are kept on file together with a record of all prenatal and postnatal calls.

District nurses make one monthly prenatal call in homes where they are going to give after-care. Maternity nurses make one call each month for the first five months, twice each month for the next two months, weekly during the last two months of pregnancy, and at least one post call.

The Fee.—The fee for the delivery service was ten dollars in the beginning. After a time it seemed advisable to vary this according to circumstances and according to the length of time spent on a case.

The Equipment

A pack, sterile, containing two small sheets, one pair leggings, six towels, four safety pins, cord ties, cord dressings, package of eight cotton pledgets, one apron, package of six perineal pads.

A bag containing a rubber apron, one butcher's apron, enema tube, two small basins, two-inch lysol packing, paper towels, hot water bag, vaseline, slides, sterile applicators, adhesive, small containers of lysol, green soap, alcohol, bichloride, boric acid solution, boric acid powder, mineral oil, iodine, castile soap, birth records, two thermometers, two haemostats, two pair scissors, one thumb forceps, hypodermic needles, thread, ergot, cotton, safety razor, abdominal and breast binders, note book, ether, ether mask, and silver nitrate.

The patient is instructed to make pads for the bed, and perineal pads which are brought to the office and sterilized and returned. One obstetrician has a printed list of articles the patient must have ready for the confinement.

For taxi service at night, the fare is collected from the patient, or the physician may call for the nurse and take her home.

Outline of Technic as Prepared by Committee

Preparation of Patient:

Upon arrival, nurse should first make rectal examination and report findings to physician. Then see that patient has a cleansing sponge bath and S.S. enema; after which vulva is shaved and prepared with soap and water, and lysol and bichloride solutions (afterward being covered with sterile pad or towel).

Conduct of Labor:

Things to have ready:

1. Water boiled and cooled.
2. At least two pans boiled and sterile (three if running water is not in house).
3. Two pans of boric solution with cotton pledgets for cleansing eyes and mouth of baby.
4. Six sterile towels and one pair of sterile leggings.
5. Ether mask, ether, ergot, silver nitrate, lysol, cord tape, alcohol, gloves, cotton and gauze.

Immediately following delivery nurse should attend to eye medication. Baby should then be oiled and cord dressed under supervision of physician.

Patient should then be prepared with abdominal and breast binders, external heat, etc.

Nurse should remain in house at least one hour following birth of baby in order to observe condition of baby, mother's pulse, and fundus, in order to guard against post partum hemorrhage.

Maternity Report from May 15, 1923, to December 31, 1923

Cases from prenatal clinic	3
New cases	29
Entered by V.N.A.	72
Total	104

Of these 104 cases:

90 were normal cases
10 were abnormal cases
4 were stillborn cases
67 paid for services
37 charity cases
85 were given after-care by V.N.A.

Conclusion.—On the whole, we feel that this department is a success, in that it is an opportunity for our mothers to receive proper care, and our babies to start life at the best advantage.

MISS EVELYN WALKER DECORATED

From a letter sent us by Freda M. Caffin, Miss Walker's Assistant

Evelyn T. Walker

MANY public health workers in America have already heard of and rejoiced in the bestowal of the Cross of Chevalier of the Legion of Honor on Miss Evelyn T. Walker, *Directrice de L'Association d'Hygiene Sociale de l'Aisne.* And I imagine the work of *L'Association d'Hygiene,* which is the direct descendant of the American Committee for Devastated France, operating in Soissons and the surrounding villages, is already too well known to need description. But possibly some of the details of the ceremony of investiture may be interesting to your readers, especially when they realize that Miss Walker's distinction was won, not under the stimulus of a critical emergency, but by steady, forceful, day-by-day construction of the routine of a Public Health Organization adapted to the needs of the people and their ability to support it—a task often monotonous, sometimes discouraging and always arduous.

The ceremony took place at the fête given by the American Committee for Devastated France in the grounds of the Chateau of Blerancourt, the site of their first activities during the war, from which in company with other refugees they were forced to fly from the advancing Germans, to return later to find nothing left of their former homes but melancholy ruins. Now that the desperate emergency of the ensuing period of reconstruction is over and the American Committee is retiring from France, it has bought the chateau, converted its grounds into a charming garden and at this fête celebrated its transference, in which was typified the transference of all its other organizations of permanent value, to the people of France.

Prominent among these organizations is *L'Association d'Hygiene Sociale de l'Aisne,* which in connection with its pioneer work for public health is training a group of enthusiastic young nurses to carry on and spread an efficient service over the whole land of France.

The ceremony of investiture, at which the Cross of Officer of the Legion of Honor was bestowed on Miss Ann Morgan, founder of the American Committee for Devastated France, and on Mrs. Murray Dike, its president, while the Cross of Chevalier of the Legion of Honor was given to Miss Scarborough, Miss Perkins and Miss Walker, was conducted by Marshal Petain, formerly commander of the Allied forces in this section of the country, who has thus been closely in touch with the work of the American Committee from the early days of its war work until now.

So little did Miss Walker anticipate the honor she was to receive that when her name was first announced, only a frenzied search found her in a sequestered corner where she could participate in the proceedings without being seen. It was a thoroughly bewildered candidate who was almost thrust forward to receive the much-prized decoration.

BOARDS OF DIRECTORS

Discussion on Administration of Public Health Nursing *

By Eleanor B. Green
Providence, R. I.

On April 10, 1924, the Rhode Island Branch of the National Organization for Public Health Nursing met to discuss the administration of public health nursing in Rhode Island. The subject was presented from the point of view of both staff and board, by nurses and managers active in the work and representative of the various types of organization. The summing up of the discussion from the point of view of the board follows:

Outline: For the Board of Managers
A. Team-work—essentials.
  I. Education of Managers.
  II. Leadership of Director or Superintendent.
  III. National Organization for Public Health Nursing.
B. Conclusion.

A. *Team-work*

Perhaps the main point to mention as a result of the discussion, which has been an admirable one, is the need of team-work by staff and board; and team-work of a high order. The few minutes at our disposal might well be focussed on this one point, and on the suggestions made for attaining it.

As health is the watchword in the work and not sickness—so in discussing the board, strength should be the watchword, and not weakness. How can a board ever be strong enough to do its part in team-work with the nurses? This seems our question, to which to find an answer.

Three ways occur to me from what has been said. The first is:

I. *Education—education of ourselves as managers—in public health nursing*

To be intelligent is not enough. To be representative of good things in the community is not enough. The administration of public health nursing depends upon something beside our record as lawyers, or housewives or business men, etc. The fact that we know something, or even all there is to know along these lines, is probably a proof that we do not know much about nursing.

Always we have been interested in the education of the nurse, but how about our own education? The community has been interested in having its nurses carefully trained, but it does not raise its voice against an uninformed governing body. And the war—the war gave a great impetus to the nursing profession, but not to the boards of managers.

Team-work is difficult, when one side is marking time, while the other is champing at the bit. But there is a way out for us, and we know what it is—

a. It is the seeking for knowledge concerning public health nursing, and
b. The enriching of our powers thereby.

The methods are much the same everywhere. They are briefly:

1. The carrying of the work always as a primary responsibility.
2. Reading and study of reports, The Public Health Nurse magazine, and books.
3. Meetings: Attendance at:
   a. our own regular ones.
      1. at which the director or nurse in charge is present.
      2. at which reports are discussed.
      3. at which statistics are interpreted.
      4. at which something distinctively educational is presented.
      5. at which the nurse in the field often appears to tell of her own work.
   b. the Conferences.
   c. the Conventions.
4. Visits.
   a. To the office: in order
      1. to talk with the director, or nurse in charge.
      2. to learn of methods and organization.
      3. to meet the nurses.

* Read at the quarterly meeting of the Rhode Island State Branch of the National Organization for Public Health Nursing, April 10, 1924.

4. to see, from time to time, demonstrations of the work.

b. To the district, to clinics and homes, in order

1. to feel the vital touch.
2. to feel the reason for the whole structure.

Our theoretical knowledge should be supplemented by personal knowledge of nurse and patient. But after we have studied and read and thought; after we have attended meetings and conferences and conventions; after we have entered into discussions and conversations and interpretations of records and reports and statistics; all these things we can label; "virtues that are not enough." There still remains the great gulf fixed between ourselves and the nurses. But it is a gulf that can be bridged by the nurses on one side, and the managers on the other—if the director or superintendent is the keystone of the arch. This, as I take it, is the second essential in team work by staff and board.

II. *The director, the nurse in charge, as leader*

I have called the director the keystone of the arch, because she alone knows public health nursing in all its branches and phases. Therefore, neither meetings nor service can be effective without her. The director is the executive head, the expert. She is the leader. And a leader who, as Moses of old, must needs have her "hands stayed up on the one side and on the other" by staff and by board—that her "hands may be steady until the going down of the sun."

And the third essential in team-work of staff and board is surely our

III. *National Organization for Public Health Nursing*

The National Organization has from the beginning been as our great prophet. From the beginning it has included us, lay members, as well as nurse members.

From the beginning it has tried to teach us that we can give but little value unless we are taking in what is of value.

From the beginning it has held wonderful conventions to which we managers have been urged to come. I think, however, we should dread to know the exact number that have ever gone up from Rhode Island—or from any other state.* We recognize the benefit it is to have the nurses go, without realizing that we could double or treble that benefit if we would only go ourselves also.

It is really the National Organization that makes us feel we are trustees only for our community; and trustees who should give frequent and full account of our stewardship. It is the right of the community to be kept informed as to its nursing service. And it is the duty of the managers to give out the status and needs of the service, in ways that are readily understood. The means chosen for raising funds should have a real educational value. Tag days and campaigns offer great educational possibilities.

The National Organization shows us that we have a distinct place, however small, in the public health movement.

It stimulates our interest in communities not our own.

It makes team-work for us possible, and it enlarges the meaning into co-operation with allied workers as well.

Conclusion

In summing up for us who are managers—and I hope I am interpreting aright for our various types—I would say:

I. Public health nursing, to fulfill its purpose, demands team-work of staff and board.

II. As managers, to fulfill our part, we should

a. Seek knowledge, and feeling, based upon the knowledge.

b. We should recognize the director or nurse in charge, as leader.

c. We should see to it that the shining thread of the National Organization running all through the fabric, enlightens us, enriches us, and binds us together.

* Thirty was the total number of representatives from Boards of Managers at the Convention in Detroit, June, 1924.

MANUAL BREAST EXPRESSION USED AS AN AID IN BREAST FEEDING

By Margaret H. Hope, R.N.
Superintendent of Nurses, Babies' Dispensary and Hospital, Cleveland, Ohio

EVERY individual or organization doing any type of infant welfare work stresses the fact that mother's milk is the best and safest food for the infant. Few of us, however, have been practising "manual breast expression" as an aid to stimulate and increase the supply of breast milk.

This organization has always insisted upon breast feeding whenever possible. We feel that even a small amount of breast milk is better than none. Recently we decided to inaugurate a regular campaign to educate the community in the importance of breast feeding, using "Manual Breast Expression" as an aid in stimulating and increasing the amount of breast milk. We obtained permission to send three of our nurses to the Infant Welfare Society of Minneapolis, pioneers in this work, to study and observe their method in breast therapy. It is not my purpose to go into the detail of technique of manual breast expression as both Miss Peck, in the June issue of this magazine, and Dr. Huenekens in the June issue of the *American Journal of Nursing* have so ably and thoroughly covered the subject; but to describe how we have adapted another organization's methods and technique to our needs.

Our problem is somewhat different to that of Minneapolis, inasmuch as we have a much larger mixed foreign population. The high wages offered to this class of labor often tempt the foreign mother to seek employment in factories, cleaning office buildings (mostly at night), or to enter domestic service.

The work was started January 21, 1924. We planned to cover the entire city, dividing it into three districts. Various public health agencies of the city were informed of our plans and their coöperation enlisted, especially the Division of Health. Our nurses visit the Infant Welfare Clinics of the Division of Health five mornings a week (10:30 to 12:00). The physician in charge of the clinic refers to the breast therapy nurse any mother who is needing this instruction. The nurse explains and demonstrates the technique of breast expression to the mother while in clinic, and follows this with a home visit to see that the mother is carrying out the instructions. The mother is told to report back to the clinic in one week so that the baby may be weighed and the physician check up on the feeding. Supplementary feeding is discontinued as soon as the supply of breast milk is adequate. Not all cases, however, can be entirely breast fed, but at least we have secured for the baby as much breast milk as possible and educated the mother at the same time. Should there be more children they stand a better chance of being entirely breast fed. The Division of Health physicians and nurses are constantly referring cases to us that come under their observation outside of the clinic. The breast therapy nurse also works one afternoon a week in the Babies, Dispensary and Hospital's sick clinic.

Maternity Hospital (affiliated with Western Reserve University), send to us a list of their discharged ward cases. These infants are not as a rule more than three weeks old. Our nurse calls on each case and whether the infant is entirely breast fed or not, talks to the mother about the advantages of keeping her child on the breast and explains manual breast expression. She is told if her milk begins to decrease to begin expressing at once. The nurse leaves her name and telephone number with the mother so that if she needs any further information or advice she

can get in touch with her at once. These cases are all referred to the Prophylactic Infant Welfare Centers.

In an article by Dr. H. T. Gerstenberger, entitled "Plan to Increase Breast Feeding," * he makes this point: "The Babies Dispensary and Hospital desires to make it a special point to announce, that any family physician wishing the services of these nurses for private patients, can secure same by telephoning to the superintendent of nurses at Babies' Dispensary and Hospital." The response of the private physician to this announcement has been most gratifying. A number of them are asking for this service repeatedly. We do not visit the private physician's case unless he himself makes the request. No fee is charged for this service.

One obstetrician and one pediatrician have sent their office nurse to us for this instruction. Two East Cleveland public health nurses and several private duty nurses have also been instructed.

We find there is such a thing as too much breast milk. Mothers often tell us they have a sufficient amount of breast milk, but the baby does not gain.

On examination we usually find engorged breasts, the milk flowing freely without the baby making any effort to secure his food. The result is the baby fills up on skim milk. Every nurse, of course, knows that the cream of breast milk is obtained at the last of the nursing. In such cases we ask the mother to first express a certain amount of breast milk into a sterile receptacle, then put the baby to the breast until it is emptied. If the child is not satisfied after emptying the breast, feed at least a part of the expressed milk.

Manual expression is much more efficacious than the breast pump and in cases of sore or cracked nipples is very much less painful. Ask any mother who has used both. The old idea of allowing breast milk to dry up in one or both breasts because of sore nipples or caked breasts is not necessary. Caked breasts may be softened by applying hot compresses, and then expressing the milk into a sterile receptacle. Sore nipples may be treated in the usual way and the milk expressed. Do not throw the expressed milk away but feed it to the baby. After the nipples have healed and the breasts become normal, the baby may be put back on the breast without any diminution of the milk supply. Many babies have been put on artificial feeding for no better reason.

In cases where the mother does not wish to nurse her baby, she can invent many reasons and excuses for not doing so. It is this type of mother that will test the resourcefulness of the nurse. It is not at all unusual where stimulation by manual expression has been successful, to have the baby gain from four to seven ounces, even the first week after supplementary feeding has been discontinued.

We find most of the criticism of manual breast expression is due to a lack of understanding. One physician remarked that he did not approve of handling the breasts, the sensitive tissues could so easily become bruised and untold harm result. This physician failed to understand that in manual breast expression we do not handle breast tissues. Manual breast expression properly done can do no more harm than the suckling of the babe.

We have failed in some instances to establish breast feeding; sometimes because the mother failed to coöperate, sometimes, I am sorry to say, because the physician failed to coöperate. However, our successes far outnumber our failures.

We believe so thoroughly in the importance of this work that we hope to add two more nurses to our present staff January 1, 1925. From January 21st to August 1st, three nurses have taught 1132 mothers manual breast expression. They have made 2173 follow up calls on these mothers.

* Academy of Medicine Bulletin, February, 1924.

SECTION ON PUBLIC HEALTH NURSING OF THE AMERICAN PUBLIC HEALTH ASSOCIATION, OCTOBER, 1924*

At a meeting in 1923 of the American Public Health Association, the section on Public Health Nursing, which up to that time had been a provisional one, was made a permanent section. At the meeting in Boston, Miss Margaret Stack was elected chairman, Mary Laird, vice-president, and Agnes Martin, secretary. Grace L. Anderson and Elizabeth G. Fox were elected members of the section council.

We suggest that nurses interested in this important development of our work with that of public health officers and other sanitarians turn to the December, 1923, number of our magazine and read Miss Stack's excellent editorial, and Miss Fox's equally excellent account of the 1923 meeting of the section.

The program of this section for this year competes, we think, in general interest with the programs of other sections.

FIRST SESSION—OCTOBER 20

Report of Committee to Formulate Standards for Positions in Public Health Nursing. Mabelle S. Welsh, R.N., East Harlem Nursing and Health Demonstration, New York City.

Discussion: Academic Education and Public Health Nursing Training. Gertrude E. Hodgman, R.N., Educational Secretary, N.O.P.H.N., New York City. Public Health Nursing Experience, Ruth Houlton, R.N., Director Public Health Nursing, State Board of Health, St. Paul, Minn.

General Discussion: Arthur T. McCormack, M.D., State Commissioner of Health, Louisville, Ky.

SECOND SESSION—OCTOBER 21

Joint Session with Public Health Administration Section

Essentials in the Administration of a Public Health Nursing Service. R. G. Leland, M.D., Columbus, O.

Discussion: Walter H. Brown, M.D., Director, Child Health Demonstration, Mansfield, O. Grace Ross, R.N., Detroit, Mich.

Some Experiences in Public Health Nursing for the Promotion of Maternity and Child Hygiene. M. S. Fraser, M.D., Epidemiologist and Corresponding Secretary, Provincial Board of Health, Winnipeg, Man., Canada.

Discussion: Merrill E. Champion, M.D., Director, Division of Child Hygiene, State Health Department, Boston, Mass.

Administrative Control of Contagious Diseases. Charles V. Craster, M.D., D.P.H., Health Officer, Newark, N. J.

Discussion: Louis I. Harris, M.D., Director, Bureau of Preventable Diseases, Department of Health, New York City, and D. C. Bowen, State House, Trenton, N. J.

Four Years' Experience in Public Health Administration Without Medical Inspection. Francis E. Harrington, M.D., Commissioner of Health, Minneapolis, Minn.

On October 22nd there will be a Public Health Forum, at which Dr. W. S. Rankin will preside. The subjects under discussion will be:

The Nursing Service: When to Generalize, When to Specialize. Discussion opened by M. A. Sargent, R.N., Detroit, Mich.

Should Bedside Nursing be Included in a Generalized Plan of Public Health Nursing?

The Use of the Active and Latent Interest of Civic and Religious Organizations in Public Health Work. Discussion opened by J. J. Durrett, M.D., Memphis, Tenn.

The Correlation of Official and Unofficial Agencies in the Public Health Program. Discussion opened by Charles F. Wilinski, M.D., Boston, Mass.

Elizabeth G. Fox will speak on "Carrying Health to the Home," at a luncheon session at which she will preside.

Three sessions will be devoted to a Child Hygiene program.

*For list of other important national meetings see News Notes.

ANNUAL MEETING OF HOME ECONOMICS ASSOCIATION

Conferences are usually exhausting affairs. The Seventeenth Annual Meeting of the American Home Economics Association held in Buffalo, June 30–July 3 was an exception. Little fatigue, much business, actual accomplished and great inspiration!

One factor contributing to this result was that those in charge of the program succeeded in having the major interests of home economics represented in general or section meetings or in round tables so interspersed with relaxation periods that health laws were not violated.

Home economists are vitally interested in health questions. It has long been recognized that the nutrition plays a large part, but if one had attended the textile section programs one would have been convinced that here, too, was a group that made no insignificant contribution. This year such topics were discussed, as, "Hygiene of Clothing, With Special Emphasis on Food Clothing," "Investigations as to Weight of Clothing and Respiratory Infections." A committee which had been at work during the year studying the hygiene of clothing, reported and plans were made for expanding the work.

The nutrition programs both in general session and round table were very rich. Dr. Mendenhall of Wisconsin presented a paper on "Preventive Feeding of Mothers and Infants"; Dr. Walter H. Eddy of Teachers College, Columbia University, discussed "Commercial Canning and the Destruction of Vitamins"; and Dr. Mary Swartz Rose of Teachers College, Columbia University, gave a most comprehensive and interesting paper on "Recent Trends in Nutrition."

One general session of the Association was given to considering the topic of the "Nation's Health and Our Responsibility." Flora Rose of Cornell University outlined a plan as to "Our Place in the Health Program," followed by a paper by Margaret Sawyer of the American Red Cross on "Our Place in the Program of National Health Organizations." The importance of mental hygiene being recognized, Dr. Thom of the Massachusetts State Department of Health discussed that work and why home economists should recognize its value. The session was closed by Dr. Sawyer of the Eastman Kodak Company, who showed the advance made in recent years in health matters.

LAURA COMSTOCK

BELIEVING IN SIGNS

Not Only Italians Have Superstitions

I started early that morning to bring Betty to the clinic. Betty's tonsils badly needed attention and I was so glad that at last I had succeeded in making the arrangement to have them out. Her father and mother were glad, too, and had promised to come with me at the hour I had set.

Only the day before I said to my fellow-nurse, "It is a satisfaction to deal with people like Betty's parents; they are intelligent, they know she needs the operation, and one feels sure that they will keep their word."

As I drove up to the house I sensed that something was wrong, there was no one watching for me from the window. As I entered, Betty's mother greeted me with: "We have changed our minds about Betty. She can't be operated on to-day because the signs are wrong."

"The what?" I asked, bewildered.

"The signs," she replied. "They are in the head to-day and we are afraid she will bleed. Come, I'll show you the almanac."

"Oh," I said, struggling for self-control against my exasperation and amusement, "do you really mean to tell me that you believe in those signs?"

"Of course we do," she said. "After we looked it up and found the signs were wrong we couldn't think of having it done. But between the 15th and 21st of the month will be all right."

"But why didn't you let me know that you had changed your mind?" I asked.

"Why, I never thought of its making any difference to you," she replied.

Well, what was the use of argument? Betty will be operated on between the 15th and the 21st, "when the signs are right."

ETTA A. CREECH, *Public Health Nurse, Huron County, Ohio.*

POLICIES, PROBLEMS AND SUGGESTIVE DEVICES OF PUBLIC HEALTH NURSING SERVICES

(Our New Department)

SOME QUESTIONS TO START WITH

At two informal meetings of executives of public health nursing organizations at the Detroit Convention, the following questions were brought up and discussed. It would, we think, be interesting to follow up the discussion of some of these, through this department. Members please contribute.

1. What is the function of a Nursing Committee?
2. How often does the Nursing Committee meet?
3. What can be done to help Board members know the members of the staff?
4. How do nurses on small staffs relate their problems to their Board?
5. The question of turnover in the staff.
6. How often should nurses report at office?
7. What provision is made for rest period at noon?
8. Automobiles—How do nurses learn to run automobiles? Who pays for lessons? If nurse owns car what financial arrangement is made with her? Are nurses permitted to use cars in off-duty time? Budget for use of cars.
9. Arrangements for work of nurses on Sunday.
10. The question of collection of fees.
11. Per cent of unproductive visits—Is appointment plan successful?
12. Limitation of home visits through patients coming to office, especially with prenatal patients.
13. The type of service that can be given by the Medical Advisory Committee.
14. Physical examination of staff members. Arrangement and payment for this service.*
15. Are we at the point where we can suggest larger budgets for social agencies, after studying community, with the idea of turning over to agencies some nursing problems?
16. Giving insulin in homes.
17. Taking cases under care of osteopath and chiropractor.
18. The question of caring for patients under the care of midwives.
19. How to conduct an interview. Time spent, right kind of question, explanation of organization, etc.
20. Pensioning nurses who have been on staff for a long time.
21. Organization and scope of Staff Councils.

Pedo-graph of a Normal Foot (Right)

THE PEDO-GRAPH AS A TIME SAVER IN THE POSTURE CLASS

As used by the East Harlem Nursing and Health Demonstration, New York City

For the routine foot examination in the posture class, the Pedo-Graph is quite satisfactory. This consists of an inked pad, over which is placed a paper (shown in the illustration).

The child steps on the paper, and the impression is made. There is no painting of the foot, with subsequent washing of same, and cleansing of brushes. The results are quite as satisfactory as with the painting method, and there is appreciable time saved.

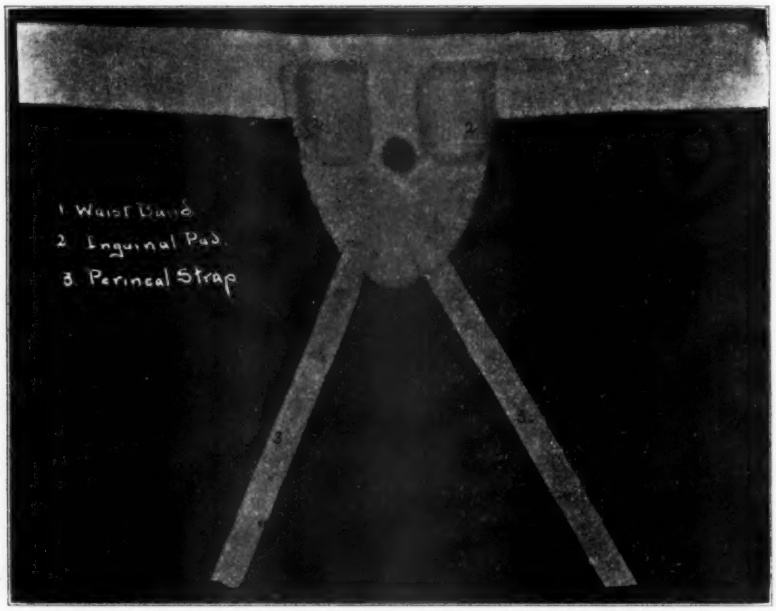
Illustration from Dr. Scholl's Pedo-graph Chart for Foot Trouble Analysis and Shoe Fitting

* This question will be discussed in the November number.

HERNIA SUPPORT FOR INFANTS

The hernia support for infants illustrated below is one we are using most successfully in the Infant Welfare Department of the Louisville Public Health Nursing Association. We found many babies in our districts with inguinal hernia in which the hernia would descend into the scrotum and cause great discomfort to the baby as well as distress to the mother over the baby's condition. We tried different ways of relief which did not prove satisfactory.

The support was finally devised. It seemed to be the very thing needed, being easily adjusted, cheap to make, and by having a number on hand, easily kept clean. We are now using it for all our hernia cases with excellent results.



The material used is outing flannel. Cut the waist band 3¼ inches wide by 17 inches long. When the edges are turned in and finished it will be 1 1/3 inches in width and 16½ inches in length. The scrotum flap, to which inguinal pad is attached, is cut a double thickness of material. Overcast the outer edge, also the penis opening, the same way as in making an eyelet. Avoid stretching. Inguinal pads are 1¼ inches long and 1 inch wide when finished. A half-inch thickness of cotton is used for padding. Place inguinal pad directly in line with middle of penis opening, attach perineal straps five-eighths inch from center of scrotum flap. It can be made to fit any child by enlarging pattern.

The band, which is adjustable, is first fitted very snugly around the waist, the penis is brought through the opening in the scrotum flap, care being taken to see that the compresses fit over the openings of the rupture, then the tapes are brought down around the groin and up to the back, looping and tying them to band in back.

A finished band is given to the mother and the nurse demonstrates to her how it should be adjusted on the baby. The mother can then make as many as she needs from the paper pattern given her with instructions for making the support.

Emma Parmelee,
Supervisor, Infant Welfare Department, Louisville Public Health Nursing Association

RED CROSS PUBLIC HEALTH NURSING

Edited by ELIZABETH G. FOX

SAMPLE SCHOOL LETTERS FOR 1924–25

LAST year a series of sample letters to be used in connection with rural school nursing was prepared for the Red Cross public health nurse and offered as a suggestion for bridging the long time intervening between infrequent visits to her schools. For it is generally recognized that the nurse's visit usually kindles sparks of interest and enthusiasm for healthy living which seldom in this busy world grow into a conflagration without fanning. Adequate fanning by the rural school nurse is almost precluded by such physical limitations as weather, distances and number of schools. Yet if the kindling is worth undertaking, the fanning must be arranged for—hence the monthly school letter. The 1923–24 series included six letters for children dealing with healthy practices, and six for the teacher suggesting reference sources and activities for the children which might be linked up with their letters.

These sample letters were designed to be adapted to the varying local conditions and made personal or specific according to each nurse's peculiar problems.

Inspiration for the preparation of a second series of sample letters has come from the wholehearted approval which the first series received, the wide range of useful purposes to which it was turned, and the knowledge that a great number of nurses were aided.

The 1924–25 series includes nine each for teacher and pupil. It differs in at least two respects from the 1923–24 series though it follows the same idea of adaptability to local conditions.

These letters are based wholly upon the suggestions in the Junior Red Cross Calendar for children's activities as given month by month in the "Fitness for Service" section. At the same time they strive to follow the teaching precept underlying the Junior Calendar which is to provoke such thought, interest and activity that the child teaches himself. Consequently the letters to the children are incomplete stories, stories which it is hoped will set them on the trail of the half-revealed facts about life. The letters to the teachers contain the nurse's ideas of the possibilities for health teaching hidden in the children's letters.

The fourth letter to children dealing with water contamination to be used in their "Fitness for Service Club" consideration of "desirable rules for drinking" is quoted as an example:

Dear Boys and Girls:

In your "Fitness for Service Club," this month, you will, if you follow your Junior Calendar, adopt certain rules for drinking water. And so I am sending you a story about water—the reason why, I'll let you guess.

Drip, drip, drip, the rain—or was it snow?—fell off the porch roof. Jane was by the east window sewing on doll clothes; Tom was stretched out on the big davenport listening to the drip, drip—when, marvel of marvels, before Tom bowed seven round, fat brownie-like little creatures—and as he stared, they joined hands and danced a sort of jig and they sang some songs whose words Tom couldn't catch except one line, "We're drops of H_2O—O-ho!—of H_2O—Oho!" As they danced they shook just like the drops that hung on leaves, thought Tom, and some were transparent and others were not. The dance ceased and there they all were bowing again; and then the first little "drop of H_2O" stepped forward and made a profound bow. "My name is Hail," said he; and then came another one to make a bow. "My name is Ice," said he; and then another one, "My name is Snowflake," said he; and then another, "My name is Lake," said he; and then another, "My name is Spring," said he; and then another, "My name is River," said he;

and then came the last one, "My name is Well," said he. "I cut," said Hail. "You can pack me away," said Ice. "You may admire my beautiful form," said Snowflake. "I am for bathing," said Lake. "You may drink me," said Spring. "I am muddy," said River. "I am no good," said Well. "No Good?" said Tom, "Oh, why are you no good?" for he liked the look of the last little drop of H_2O.

"I am kin to all others, but I am Spring's brother. We came from the same home, a deep place beneath the limestones, many, many miles from here and many leagues beneath man's feet.

"Out from our house ran little stone-lined ways, and one of these Spring and I with lots of our brothers followed. We ran a long way until one day we came to an opening where Spring and many other brothers jumped out to see the light, and the flowers, and the ferns, but I ran further on until I came to a nice wide place in the stoneway. Here, thought I, I shall rest. Then presently I noticed that this place was not like my other home; there was no stone over my head, only earth. Drip, drip, drip, little drops of fluids came tumbling down and fell right between me and my many brothers. 'Where do you come from?' said I. 'We're from the barnyard just a little way above,' said some. 'We're from the pigs' wallow in the hollow,' said others. 'Did you come through stone?' I asked. 'No, just earth and some coarse gravel. We slipped through easily.' They did indeed. With them were bits of things which we liked not. We stayed there in the pocket a long, long time and then one day I felt myself being lifted up through something which was cool like stone, but was not stone, and then directly, I was spilled out into a test tube—that's what I heard a voice call it—and we were taken to a laboratory. Many things happened to us there and then the same voice said quite sternly, 'That H_2O is dirty; to be used it must be . . .'"

"Boiled!" yelled Tom, and sat right up.

"Good gracious, Tom, do you think you're out with the boys? Mother doesn't . . ."

"Say Jane, I was dreaming and about water, too. Do you know how clean water gets unclean?"

"I know one way—when YOU bathe."

"Huh, sis, you mean when YOU do! But honest now, serious like—how many ways can you name?"

"Uncovered pails at school . . . dirty cups dipped in . . ."

Boys and girls, I'll just let you finish this story.

What do you know about the ways by which clean water becomes unclean? What do you know about the ways by which unclean water is made clean? How would you go about determining whether or not water was safe to use?

Have you ever heard an expert well-driver tell how to find water and to build wells that are always safe to use? Have you ever had one of the bulletins from the State Board of Health called "Safe Water"?

Merry, Merry Christmas to you!
Your A.R.C. Public Health Nurse.

This series it is believed will follow suitably the series of last year. It may be used also in schools familiar with Junior Red Cross or for schools whose teachers are familiar with or experienced in health education.

THE INDIAN PUBLIC HEALTH NURSING SERVICE

On March 25, 1922, Mr. Charles H. Burke, Commissioner of Indian Affairs, Department of the Interior, asked Judge John Barton Payne, Chairman of the American Red Cross, for the assistance of the latter organization in making an investigation of the need for public health nurses on Indian reservations. Mr. Burke requested that the American Red Cross assign "enough nurses to make a complete survey of several reservations."

The American Red Cross agreed to undertake such a study and accordingly, in consultation with Mr. Burke, laid out a plan embracing a survey to be made by a public health nurse of health conditions and of the nursing and field matron services on several reservations in the southwest and two experiments in establishing public health nursing services, one on the Jicarilla Reservation in New Mexico and the other on the Pine Ridge and Rosebud Reservations in South Dakota.

On October 1, 1922, Miss Florence Patterson was appointed by the American Red Cross to make the survey. Her investigation was confined to the southwestern states, including New Mexico, Arizona, southern California and southern Colorado and covered a period of nine months.

In November, 1922, Miss Augustine

B. Stoll and Miss Elinor D. Gregg were sent by the American Red Cross to the Jicarilla Reservation and the Pine Ridge and Rosebud Reservations, respectively, to demonstrate the feasibility of establishing public health nursing on Indian reservations.

Miss Patterson's nine months study plus the experience of these two nurses furnished opportunity to make observation sufficiently broad to form a conception of the need for a nursing service reaching the homes of the Indians, of the essential qualifications of a nurse who could best furnish this service, and of the kind of direction and type of organization which would make it possible for her to obtain maximum results.

These observations and conclusions and recommendations drawn therefrom were embodied in a report prepared by Miss Patterson and presented to the Bureau of Indian Affairs by the American Red Cross in June, 1924.

As a result of this study and demonstration, a public health nursing service is to be established in the Indian Bureau. Miss Eleanor D. Gregg has been selected as the first "Supervisor of Field Nurses and Field Matrons." All who are interested in the welfare of the Indians will be glad to know that they are to have the benefits of public health nursing. The creation of this service opens up another avenue for effective and gratifying service for public health nurses.

"Public Health will be the biggest thing in China for the next ten years," writes Miss Cora E. Simpson, whose reports of the accomplishments of the Nurses' Association of China are always full of interest. Let her describe the magnificent quarters she secured for the health work conducted by one of the Chinese nurses.

In one of my trips in far away Shansi one day they asked me to stay over a day and go to see the health work one of our Chinese nurses, a young man, was doing in a nearby city. We started early in the morning and after a ride of two or three hours in a springless Peking cart we reached the city and were welcomed by the people. There was no place available for the lectures and demonstrations to hold the crowd that came. The nurse felt this was one of his greatest handicaps. During the morning I was taken to call on the "great family" of the city. I had expected something wonderful but nothing like the magnificence of the mansion to which I was taken. It was one of those beautiful old Chinese mansions—courts, paintings, rooms and more rooms until one was lost in the wonder of it. The family had departed this life until only a few members remain in the old home. We were received most graciously, as one always is in China. We drank tea with the lady and then our host appeared and we talked of China and her needs and the host spoke of the help his family had once been to the nation. It came to me to ask for this mansion for the nurse and his health work. I have found that if you ask you generally receive. So I asked and told them that in this health work they would again be helping China and her babies by allowing their home to be used for the lectures and demonstrations.

They listened graciously, and then, after consultation, said it could not be done because of traditions. I explained that China was a republic and the man who serves his country most is greater than even the greatest emperor. After more tea and conversation we departed, I feeling the end was not yet. While we were at dinner with another family the host of the mansion came and said, "When do you want to have that meeting? You may use my house all you wish for I want to serve China too."

The nurse now is carrying on his health program in this lovely old home, the babies crawling about the courts and men and women listening under the wonderful carving of the ancestral hall. The city will eventually feel the pulse of new life when the people have learned to be stronger and better and when their homes are happier because they are healthier. I am sure you will agree with me that this man is indeed serving his country as his home is used to help China's needy ones.

REVIEWS AND BOOK NOTES

PUBLIC HEALTH NURSING

By Mary Sewall Gardner

Second edition, completely revised.

The Macmillan Company, New York, 1923. Price $3.00.

The completely revised edition of Miss Gardner's book on "Public Health Nursing" is as welcome, and almost as much needed, as the original. Not that there has actually been a profound revolution either in our conception or practice of public health nursing for, as Miss Gardner states in her preface to the second edition: "There has been in these eight years no complete overthrow of once accepted principles and no radical change of method. Rather there has been a development of ideas, clearly indicated before 1916, but necessitating a shifting of emphasis of expression on every page."

However, this very change, though it may be in terms only of emphasis rather than of a complete overthrow, taking place in a movement that has been growing with such startling, in fact overwhelming and terrifying rapidity, has left most of those in the ranks of public health nursing gasping and hurrying—always trying to catch up but with no time for the kind of quiet contemplation that gives perspective and a sound basis for judgment. This is just what Miss Gardner's book does—it catches us up and shows us the way ahead, not with hard and fast finality but with judicial consideration of various possibilities and present trends. Controversial questions are discussed with a discriminating presentation of all sides and no simple categorical answers. Individual and independent thinking is stimulated and no one is allowed to be complacent or satisfied with her own settled convictions. Even the findings of the much quoted Rockefeller report are not accepted with finality!

Just the index alone of the new edition is revealing of the shift in emphasis. As many pages are given to public health nursing under public auspices as under private auspices. Who would have believed that eight years ago? Also the heading of one chapter, "Group Management," within only very recent years would have found its place in any book on nursing. Possibly no chapter is more clarifying or more illustrative of the need for slow judgments than the one on "Modern Problems." Herein is found a careful consideration of some of our most perplexing questions with a wise plea for open minds and willingness for further experimentation.

The material is admirably assembled and is so logically presented and divided that it lends itself particularly well for reference work. The author's use of resources either in quotation or for reference brings the reader immediately in touch with the most up to date and authoritative consideration of a given subject.

Here then in this book, through the expenditure of someone else's time, we find just the perspective we needed. It points out no easy right way but its wise counsels stimulate us to more careful thinking and new endeavors. It commends itself equally to the young eager public health nurse wondering what it is all about and to the older, more tired public health nurse who feels it is about too much; and to Board members and other non-nurses who have done so much to further the cause of public health nursing. None of these can afford to miss reading and owning this revised edition of a book many consider the public health nurse's Bible.

KATHARINE TUCKER

PEDIATRIC NURSING
ITS PRINCIPLES AND PRACTICE

By Bessie Ingersoll Cutler, R.N.
The Macmillan Company, New York, 1923, $3.50.

It is always a pleasure to handle a well made book. One is naturally led to explore its pages. If it is technically sound and leads one from paragraph to paragraph within a minimum of strain and a maximum of instruction it is a good book to put into the hands of students. Such a volume is Miss Cutler's new book on Pediatric Nursing. As a text and reference book on practical methods of nursing technic for children it is admirable.

Its illustrations are well chosen and emphasize the subject matter at hand. The simple line drawings make it easy to understand the principal types of apparatus used.

Miss Cutler acknowledges at the very first her indebtedness to a number of outstanding pediatrists. She plainly states that "the book is not intended to be complete in itself, but is to be used as a text on the nursing care of children in conjunction with lectures on the diseases of children." She does, however, reveal her originality in presenting otherwise tedious details in an eminently practical manner with the needs of the student nurse ever in mind.

In the first chapters of the book Miss Cutler impresses upon the nurse the importance of an historical background to her work and of a clear understanding of the growth and development of the normal child. The hygiene of infancy and childhood receives due attention. In fact, a strong note of prevention pervades the entire volume. A chapter on the mental development of the child has been contributed by Fredericka Beard and a selected bibliography on mental development is given at the end of the book.

In her chapter on the care of the sick child in the hospital Miss Cutler displays her thorough training by giving in detail the precise methods a nurse should use in her care of the sick child.

The chapters on the newborn baby and maternal nursing would repay the careful study of every nurse. The greatest exception may be taken to the chapters dealing with the artificial feeding of infants. It is questionable whether it is advisable to set before the pupil nurse a variety of formulae upon which pediatrists are by no means agreed. The choice of certain articles of food for the dietary of children after weaning might also be questioned.

The book is brought thoroughly up to date by a chapter on the orthopedic nursing care of children by Katharine A. Smith and one on the educational value of occupational therapy by Susan E. Tracy. Altogether this new book can be recommended highly as a textbook on nursing procedures both for the sick and well child.

RICHARD A. BOLT, M.D., D.P.H.

THREE PROBLEM CHILDREN

Narratives from Child Guidance Clinic Publication No. 2
Joint Committee on Methods of Preventing Delinquency, 50 East 42d Street, New York. Price $1.00.

These narratives have to do with three children who demonstrate problems which often puzzle parents, teachers, and public health nurses and the methods used in a Child Guidance Clinic for getting at the basis of the problem in the personality of the individual child and developing an intelligent plan for fitting the child and his environment together in such a way as to make his life an asset rather than a liability.

In an introduction, the writer sets forth the purpose of the publication very concisely, as an effort "to give some indication of the resources which modern science offers for the assistance of those who seek to understand such troubled young lives and to guide them into the channels of normal social growth." The histories are elaborated simply and the teacher and the case worker, whether social or public health, will find many helpful suggestions both for resources and method.

ELNORA E. THOMSON.

ADAPTING NUTRITION WORK TO A COMMUNITY

By Lucy H. Gillett

Nutrition Bureau, A.I.C.P., 125 E. 22nd St., New York City, 1924, 25c.

Miss Gillett's late bulletin, Adapting Nutrition Work to a Community, presents in compact form, first: important factors to be considered before deciding upon a nutrition program for any locality; second: a summary of results obtained after four and a half years' work at Mulberry Health Center in New York City; third: a definite program for a "General Community Drive" for good nutrition.

By means of tables, charts, graphs, and illustrations, Miss Gillett enables us to see clearly the results of intensive home visiting; she then discusses class work for various aged groups and outlines in thirteen lessons a course for the teaching of health classes.

To those seriously minded as to the future of nutrition work as a positive health service, this bulletin comes as a message scientific in thought, alive in interest, abounding in richness of suggestions, and inspiration. It should be beneficial to all engaged at present in health work as well as those contemplating such a program.

BERTHA B. EDWARDS.

Health Education—A Program for Public Schools and Teacher-Training Institutions. No more significant contribution to the school health program has been produced within recent years than this pamphlet. This program is the latest report of the Joint Committee on Health Problems in Education of the National Education Association and the American Medical Association. For some years past the Joint Committee of the National Education Association and the American Medical Association has been studying health problems in education and has produced from time to time very useful reports, charts and other material. This latest report, however, has aimed to study, interpret and coödinate materials and methods in the field of health education so that schools and school workers could be provided with a sound program of health teaching. Dr. Thomas D. Wood, the Chairman of the Committee, says: "It is hoped that this report may provide the best available guidance to the schools of the country relative to health teaching in the immediate future." The report is not a course of study. The technical committee of educators and scientists who prepared this report agreed that no organization should undertake to provide a generalized course of study which would be used all over the United States.

It was recognized that a really good course of study in any subject, health not excepted, has to be worked out by the local people in relation to their needs. The purpose of this report, therefore, was to outline important subject matter and principles of educational psychology which should govern the use of this material and to suggest to teachers sources of material and points of view in relation to which it could best be studied.

The report contains among other topics, chapters on the following: "Essential Subject Matter for the Teacher," including such things as the Physiologic Basis of Health, Preventive Medicine and Health, Nutrition and Health, Mouth Hygiene, Hygiene of the Eye, Physical Education, Education for Parenthood and Social Hygiene, Mental Hygiene, Accident Prevention, and Health Education Through the Study of the Life Processes of Animals and Plants.

There is a chapter on Educational Problems and chapters on Suggestions for Courses of Study in Various Grades, Measurement of Results and The Training of Teachers. There is an extensive bibliography including not only books for the teacher, but textbooks, courses of study, films, lantern slides and a list of useful publications of voluntary organizations.

No health education worker can afford to be without this valuable publication. (*For address and price see school list in this number.*)

EMMA DOLFINGER.

The Tenth Annual Report of the International Health Board of the Rockefeller Foundation has just been published. The world-wide activities described carry on the feeling of wonderment at their extent, which we felt when reading Dr. Vincent's "Review" of the Rockefeller Foundation of 1923, noted in the July magazine.

We quote the following illuminating paragraphs on "Development of Rural Health Departments":

Health departments in the United States developed first in the larger centers of population. In the northeast every city and town of any size has had for many years its municipal department of health, but in the rural sections little was done until recently. The most promising of the present health organization projects has developed in the rural regions of the South, where the relationship of the International Health Board and its predecessor, the Rockefeller Sanitary Commission, to state and local health organizations, has been of longest standing. The political unit selected for this plan is the county, rather than the town or the village, because in most instances the county is large enough and has sufficient resources to warrant the employment of a full-time officer and a suitable staff.

Since 1911 every year has witnessed an increasing growth of the movement. . . . At the end of the year 1923 there were 230 counties in twenty-eight states of the United States with full-time health organizations. The number grows each year, and few counties which have given the system a trial fail to continue it and to expand the unit to meet the more obvious needs of the people. In Ohio 48 per cent of the counties now have full-time organizations, in Alabama 32 per cent, in North Carolina 31 per cent, in New Mexico 27 per cent, in South Carolina 11 per cent, and in other states, smaller percentages.

In Brazil organization of rural health work followed closely in the wake of the hookworm campaigns as a natural outgrowth. Only two years have elapsed since the first full-time unit was started, but the idea has already found favor, and county health organizations are being established in several states. The Federal Government is actively interested and has already extended its coöperation to sixteen of the twenty states, and at the present time 225 projects are under way. In Czechoslovakia the first county health program was started at Kvasice, Moravia, in 1922, and its success led to the inauguration of a second in Kladno, a coal mining center surrounded by rural districts having a population of 81,000.

The American Journal of Nursing for October, 1924, contains an article by Edith B. Wilson on *Installing Medical Asepsis.* It describes the technic used in the new communicable diseases unit of the Los Angeles General Hospital. This article is an excellent "follow up" in connection with the material published in our September number on the subject of Communicable Disease.

The Shadow Pantomine produced so effectively last year by the Infant Welfare Society of Minneapolis has been most astutely and pleasingly used as their Annual Report. *The Story of Ivan and Peter Koski,* and the mother of small Ivan, and Peter the tiny newcomer, is printed in story form with delightful silhouette illustrations (one of which we reproduce), showing how the story may be staged.

Little Peter, a nice baby, but small and so fussy

The story and pantomine pictures as prepared by Miss Peck can suggest all sorts of variants easily put together for other organizations. A note attached to the report says:

Sheet 7 x 9 stretched tight between the wings. A proscenium arch made of brown paper and colored crayons. One strong light about 10 feet back of center of curtain. The light is turned off to designate changes of time and place. Action continues during the reading of the story.

The Education Department of the National Catholic Welfare Conference intends to publish a series of pamphlets on health education. The first of the series, *Medical Supervision in Catholic Schools* has been issued. It takes up the practice of medical supervision as it now affects the Catholic School, the combinations of personnel, enters in detail into the question of cost of the service and discusses supervision. The pamphlet also contains a series of forms and a tabulated list of communicable diseases. It will be followed by a graded study of the correlation of health material with other studies—*Health Through the School Day.*

Home Play is an attractive little pamphlet issued by the Playground and Recreation Association of America, 315 Fourth Avenue, New York City. It contains Backyard Playground Equipment, Home Play for the Whole Family, and Constructive Play in the Home. Excellently illustrated—we think this should be suggestive to school nurses, as well as to parents. Price 10 cents.

CHILD WELFARE WORK IN SOUTH AFRICA

The June number of the *South African Nursing Record,* the official organ of the South African Trained Nurses' Association, Child Welfare number, has items of especial interest for workers in the field of Child Health.

The nursing organization holds a justifiable pride in their share in the recent organization of a National Council of Child Welfare, on which they have a member representative.

The outstanding article of the *Record,* "Infantile Mortality in South Africa and New Zealand," is by J. J. Boyd, M.D., D.P.H., Medical Officer of Health, Pretoria. Dr. Boyd believes that each country has its own problem, and multiple influences must be taken into consideration before conclusions are drawn about the effectiveness of any method of work.

Dr. Boyd asserts that to the appointment of Government Medical Officers for what are now the different provinces of the Union, just after the Anglo-Boer war, is doubtless due the credit for the beginning of the reduction in the infantile death rates, and that sanitation and better housing have played a large part.

The National Council of Child Welfare which was organized in May will have official control over all child welfare work in South Africa. The new proposals to establish Mothercraft Training Centers for the purpose of training nurses and other women in ante, neo and post natal work are of utmost importance. The venture is to be financed by the Department of the Interior.

Again we learn from a far away country the same facts which are prevelant everywhere, that

> Child welfare visitors, infant consultations, etc., can only produce their complete possibilities for good when the municipality has given the inhabitants the opportunities for decent and cleanly life.

With a full appreciation of what a national headquarters signifies in the United States it is startling to learn that with the formation of the new National Council for Child Welfare its headquarters are to be in one of the chief towns of each prvoince *in rotation.*

A resolution relative to the training of children is significant:

> The neglect of the health and training of the child during the first six years of its life do infinite harm and hamper the child during the remainder of life. It is therefore necessary that clear authoritative information be compiled and disseminated, setting forth:
>
> (1) How to safeguard the health of the child.
>
> (2) The need for training the child to acquire the habits of self-mastery and obedience whilst at the same time securing to it the greatest freedom to develop its own good tendencies.
>
> It being emphasized that by placing the child in the best environments available and subjecting it to as little interference as possible, self-help will be encouraged.

HARRIET LEETE

NEWS NOTES

Miss Grace Abbott, of the Children's Bureau, working with Dr. Helen A. Moore, Child Hygienist of the Division of Public Health Relations of the A.C.H.A., has arranged with several women's clubs in Illinois to put on an intensive maternal and infant hygiene program at certain selected places in the State approved by the State Department of Health.

Dr. Martha M. Eliot, a graduate of Johns Hopkins University Medical School and a member of the faculty of the Department of Pediatrics, Yale University School of Medicine, has been appointed Director of the Division of Child Hygiene of the Children's Bureau, United States Department of Labor.

A recent visitor to the offices of the National Organization for Public Health Nursing was Dr. J. H. L. Cumpston, Director General of Health of the Commonwealth of Australia. Dr. Cumpston is traveling in this country as a guest of the Rockefeller Foundation. During October he will visit London, Paris and Geneva, returning to the United States for a further short stay. Dr. Cumpston is particularly interested in nursing problems, and in the question as to the advantages of generalized and specialized nursing in the public health field. Besides interviewing Miss Stevens, he visited the East Harlem Health Center, and is at present making a trip to a number of cities in order to get first hand information regarding the administration of public health nursing and other public health activities.

Miss Olive Baggallay of London has been awarded the Florence Nightingale Fellowship for the "higher education of nurses" for the coming year. Miss Baggallay is a public health nurse who has had experience as a Queen's Jubilee Nurse and is now a Health Visitor in the Municipal Borough of Battersea in London.

The United States and the N.O.P.H.N. are very much honored that Miss Baggallay has been sent to this country to study public health nursing. She will be under the auspices of the N.O.P.H.N. in planning her year's study and observation.

Miss Alma C. Haupt, Superintendent of the Visiting Nurse Association of Minneapolis, has been accepted for an important executive position in child welfare work in Austria under the Commonwealth Fund. Miss Haupt sailed in September.

Miss Eleanor Zuppann has been appointed superintendent of the Minneapolis Visiting Nurse Association to succeed Miss Haupt.

Miss Nan L. Dorsey, whose agreeable accounts of her impressions of the International Course for public health nurses held at Bedford College, University of London, appeared in the February and July numbers of this magazine, has returned to her position of director of the Public Health Nursing Association of Pittsburgh, Pa.

Miss Lillian Hudson has returned to Teachers College, after several months abroad. Miss Hudson spent part of the summer very interestingly, in Russia with Miss Lillian D. Wald.

Miss Dorothy Deming, formerly Field Director of the Henry Street Visiting Nurse Service, New York City, will shortly become Superintendent of Nurses of the Holyoke, Mass., Visiting Nurse Association.

Miss Maude Truesdale, who has been on the staff of the Brooklyn Visiting Nurse Association, has been awarded a year's scholarship for study in public health nursing at Teachers College. The scholarship was awarded on condition that Miss Truesdale re-

turn to the V.N.A. for at least one year of service following her year of study.

Miss Beulah Gould has been appointed as the State Supervisor of School Nurses, State Department of Education, Albany, New York, to succeed Mrs. Bertha E. Mascot, who has resigned.

Miss Helen Zurawski, formerly Director of the Public Health Nursing Course in Cincinnati, Ohio, took up her duties on August 1 as Advisory Nurse for the Monmouth County Social Service Organization, with headquarters at Red Bank, N. J. Monmouth County is a practice field for Teachers College.

Miss Hulda Cron went on duty August 1 as Superintendent of the Visiting Nurse Association, Evansville, Ind.

Miss Mary Ann Mackay has become the Superintendent of Nurses of the Public Health Nursing Association of Peoria, Ill. She assumed her duties July 1.

Miss Elsie Brehaut, formerly Advisory Nurse, Monmouth County Social Service Organization, Red Bank, N. J., has become Superintendent of the Lowell Guild, Lowell, Mass.

The office of the Victorian Order of Nurses for Canada has been removed to No. 7, 501 Main Street, Vancouver, B. C.

The headquarters of the American Association of Hospital Social Workers was changed October 1 to 30 East Ontario Street, Chicago, Ill.

The International Catholic Guild for Nurses, which purposes to associate Catholic nurses together for their individual and professional welfare and to work for the interests of the profession, was organized in Milwaukee, Wis., June 25. The Guild is made up of individual membership, registered nurses forming the voting and office-holding body. A recent conference held at Spring Bank, Okauchee, headquarters of the Catholic Hospital Association, was attended by nurses from twenty localities, representing eleven states and Canada and Ireland. After the adoption of the constitution and by-laws, the following officers were elected:

President, Katherine McGovern, Minneapolis.
Vice-Presidents, Loretta Mulhern, Colorado, and Mary Sullivan, South Dakota.
Secretary, Mary Dorais, Missouri.
Treasurer, Evelyn Shea, Illinois.

Those wishing to join the Guild are invited to send their dues to Room 204, 610 Sycamore Street, Milwaukee, Wis. Catholic nurses may become voting or general members, non-Catholics may be associates by paying the annual dues of $3. This gives the right to membership in the Catholic Hospital Association and a subscription to *Hospital Progress*. Any one may become a sustaining member upon the payment of $10. Contributors make a donation of at least $100.

More than 100 nurses attended the seventeenth annual convention of the National Association of Colored Graduate Nurses which was held August 19–22 at Buckroe Beach, Virginia.

At a public meeting greetings on behalf of the local nurses' association were read by Mrs. A. Green and responded to by Miss Petra Pinn, president of the National Association. Miss Carrie Bullock spoke on "The Nurse as an Artist," and Miss Henrietta Neely discussed "The Benefit of State Registration for Nurses." A second open meeting was held at Ogden Hall, Hampton Institute.

In the annual address of the president, Miss Pinn, the nurses were reminded of the great responsibility that is theirs. She spoke at length of the Nurses' Registry in New York City, and also made an appeal to interest more nurses in the Association.

The first round table was on "The Responsibilities of the Nurse in the Maintenance of Health among School Children", Miss L. Braxton, chairman. At the round table, "Hospital Management," Mrs. J. L. Andrews, Superintendent of Nurses of John A. Andrews Memorial Hospital, Tuskegee Institute, made an address.

Other papers at later meetings included, "The Sheppard-Towner Nurse in Ohio", Miss Adele Wood; "Milk", Mr. W. H. Laurence, bacteriologist of Portsmouth, Va.; "The Plans of a City Visiting Nurse Service", Miss Blanche Webb, Superintendent of King's Daughters Visiting Nurses Association, Norfolk, Va.; "The Sympathetic Side of Nursing," Dr. Southgate Leigh, Norfolk; "The Nurse a Technician", Dr. D. W. Byrd, Norfolk; "Virginia Hygiene Educational Program", Miss Edna P. Fox, Richmond, Director of Educational Bureau of Social Hygiene; "The Benefits of Radium", Dr. Howe, Hampton, Va.

Dr. J. O. Plummer, president of the National Medical Association and a real friend of the nurses' association, delivered a timely address.

Officers elected for the ensuing year are: President, Miss Petra Pinn, West Palm Beach, Fla.; first vice-president, Miss Carrie Bullock, Chicago, Ill.; second vice-president, Mrs. C. E. Broadfoat, Sanatorium, N. C.; Recording Secretary, Miss Jayne Turner, Germantown, Pa.; corresponding secretary, Miss Willa Mack, Kansas City, Mo.; financial secretary, Mrs. A. B. King, Norfolk, Va.; treasurer, Miss A. A. Nelson, Columbia, S. C.; chaplain, Mrs. E. W. Carter, Columbia, S. C.; journalist, Mrs. J. V. Reid, Tuskegee Institute, Ala.; national organizer, Mrs. Daisy Dickerson, Chicago, Ill.

Chairmen were also chosen for the various committees. The 1925 convention will be held in Jacksonville, Fla.

"The ultimate responsibility for the health education of the child lies with the classroom teacher." The teacher is "the cloud by day and the pillar of fire by night" who will lead her children into the promised land of health and happiness. This was the opinion expressed by the educators, pediatricians, physicians, nurses, nutritionists, and public health specialists from all geographical sections of the United States who attended the Health Education Conference at the Massachusetts Institute of Technology, Cambridge, the week of June 23d to 28th.

This conference was arranged by the Health Education Division of the American Child Health Association, at the invitation of the Department of Biology and Public Health of the Massachusetts Institute of Technology. The members of the conference divided themselves into two main groups for the purpose of discussing how the teacher may best be helped to shoulder her great responsibility: The School Administration Section, of which Miss Emma Dolfinger, Staff Associate, Health Education Division, American Child Health Association, acted as chairman, and the Teacher Training Section, with George H. Black, principal of the Washington State Normal School, Ellensburg, Washington, as chairman. Professor C. E. Turner of the Massachusetts Institute of Technology was chairman of the general sessions at which the conclusions of the section meetings were presented and discussed.

A summary of the principles developed and points emphasized at the conference was presented and adopted on the closing night. The recommendations in this summary were grouped under six main heads:

The personal health of the teacher in service and the teacher in training;

The personal health of the pupil as presented in a report on the duties of physicians, nurses, teachers and parents in relation to the examination of the child:

The principles underlying the gradation of subject matter from kindergarten to college, and courses of study for the teacher in training;

The functions of the specialist in a school health program;

The care of the preschool child;

Suggested tests for measuring certain results in Health Education.

NEWS FROM THE STATES

Georgia

Public Health nurses of the First District, Atlanta, Georgia, held a dinner meeting in July. Miss Jane Van de Vrede gave a report of the convention of the National Association of Social Workers and Miss Elizabeth Robison and Miss Emma E. Habenicht gave an interesting account of the Biennial National Nursing Convention.

Michigan

The Michigan Board of Registration of Nurses and Trained Attendants will hold an examination for graduate nurses and trained attendants at Lansing, Michigan, November 12 and 13, 1924.

New Hampshire

The New Hampshire Health Institute, held at the University of New Hampshire, Durham, N. H., from June 30 to July 12, was received with great enthusiasm. One hundred and nineteen nurses, health officers and teachers registered for the entire course, and at least 259 persons attended one or more of the lectures. Those in charge of the Institute endeavored to give each worker several lectures on the particular work in which she was interested, and also to give them a new insight into the problems of other workers in the state. There have been many requests for a repetition next year.

Several of the State Organizations for Public Health Nursing, affiliated as branches of the N.O.P.H.N., are meeting this month. Members of the N.O.P.H.N. staff will attend as many of them as possible. The Arkansas meeting will be held in Pine Bluffs, October 9-11. Pennsylvania will meet in Reading, October 27-30. Miss Bears is expected to attend this meeting.

Miss Brink will go to the Utah meeting which will be held in conjunction with the State Educational Association.

The Oklahoma meeting will be held in Oklahoma City October 29-30.

October will also be a full month for State Graduate Nurses' Associations. A number of them will be attended by members of the N.O.P.H.N. staff. Miss Brink attended the West Virginia meeting which